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Reconciling Femininity and Professionalism: Female Physicians in 19th Century
America

Ayesha Anwar

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in History

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Introduction:

Elizabeth Blackwell, British-born but American-raised, was in her twenties and searching for a useful occupation. Her family was financially secure thanks to the her and her sisters' joint efforts after their father's death, but Blackwell didn't wish to marry, didn't enjoy teaching, and was too active to stay at home. She visited a family friend one day, a woman who was dying a slow, painful death of "a disease, the delicate nature of which made the methods of treatment a constant suffering for her." "If I could have been treated by a lady doctor, my worst sufferings would have been spared me." she told Blackwell.¹ Blackwell, despite detailing her own initial revulsion to the human body, became fixed on the idea. She was the first woman to earn an MD in the United States, graduating from Geneva Medical College of Syracuse, New York in 1848.

Following her graduation from medical school, Blackwell went on to study in France and England, before returning to the United States to practice, eventually opening her own hospital. She went on to offer postgraduate training for women physicians and nurses and in time opened a medical school attached to the New York Infirmary. She would later follow one of her students to England, where she would be the first woman on the British medical registry, and help found the first British women's medical college.

Blackwell's friend's story was not a unique one. The rise of professionalism meant that increasingly men were responsible for healthcare, including reproductive care and midwifery. The convergence of this pattern with the rise of Victorian ideals and societal

¹ Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Longmans, Green, and, 1895, 58-59.

propriety meant that woman often chose not to tell male physicians about their illnesses until it was too late. If only female patients could have had a confidante with more knowledge than their mothers and friends... Female physicians answered this call to action magnificently. Blackwell seemed to open the floodgates – within a decade there were other women who earned their degrees by attending a male medical school, as well as both male and female doctors who rapidly worked to create a system of female medical education. One of the resulting institutions, the Women's Medical College of Philadelphia, was a worldwide leader in regular female medical education – its alumnae included the first women physicians of Native American, African American, and Japanese ancestry, as well as a medical missionary of American descent who lived in India.²

Women physicians had a crucial role in not only providing healthcare to the female population, but also in reclaiming the authority derived from scientific knowledge and professional education, and in the use of this authority to influence not only response to disease, but also child-rearing, pre- and post-natal care, and the physical and intellectual education of women. While women had traditionally been responsible for nursing ill family members, as well as working as midwives, increasing professionalization of medicine and healthcare eliminated a lot of these avenues. Female physicians, by undergoing the traditional path of education and training, were able to reclaim this authority. In this thesis, I will study the medical education, public and professional writings, and scientific contributions of these women, in order to gain a better understanding of their role in reforming societal expectations for all women. Studying a

² Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 76.

relatively long time period, from 1848 to 1910, will allow for a more nuanced discussion of the ways in which different generations of women physicians played off the results of their predecessors and set the stage for their successors. I chose this specific period of time as Blackwell received her M.D. in 1848, and 1910 marked the publishing of the Flexner Report, which marked the end of the most pluralistic era of American medicine. The Flexner Report called for a rigid adherence to science, and resulted in the closure of most rural medical schools, most schools that did not follow strictly allopathic curricula, and many schools that could not keep up with the expenses of the newest scientific technology.³ In terms of my area of interest, this meant that many women's medical colleges were closed, and the rate of coeducation rose, and the openness of the profession, which had allowed for a period of medical pluralism, gradually ended. Flexner recommended increased government oversight and regulation of licensing agreements as compared to the looser restrictions of the previous fifty years. The Flexner Report resulted in massive shifts in the medical profession and its regulation, making its publication a good point at which to conclude my study.

There were a number of factors that made the medical profession particularly accessible for women at this time. There was little oversight from the federal government in regards to qualifications needed to become a physician. Instead, licensing requirements varied from state to state, and educational requirements to enter a medical school varied from institution to institution. Medical schools had ample financial motive to keep educational requirements as low as possible, in order to encourage more students to apply, and be accepted. This meant that entrance into a 'traditional' medical school was

³ Hudson, Robert P., and Ronald L. Numbers. "Abraham Flexner in Perspective." In *Health and Sickness in America*, edited by Judith Walzer Levitt, 148. 2nd ed. Madison: University of Wisconsin Press, 1985.

comparatively easy for most men – it was considered that men who weren't suited to any other profession often found themselves in medicine.⁴

Furthermore, there were different avenues for attaining professional qualifications – while one could only obtain an M.D. from successful graduation from a medical school, many practitioners won their professional acknowledgment from completing an apprenticeship. At this time, a multitude of medical ideologies were emerging and developing, each competing for patients – hydropaths, homeopaths, advocates of herbal medicines, and micro-dosages, among others. Some of these alternative ideologies were more open to the admission of women practitioners.

Women physicians served an important role in demonstrating through their successes that women were intellectually capable of higher education without negative repercussions to their reproductive organs. The fact that many of them were married, Mary Putnam Jacobi and Abraham Jacobi for example, proved that the pursuit of a career would not automatically preclude a woman from filling the role society expected from her – that of a wife and mother. Female physicians had to negotiate an interesting space – on the one hand, they were occupying a masculine-dominated profession—furthermore one that was notable in its gruesome nature and brute physicality, as well as aspects such as nudity of both sexes, which was seen as explicit, and death. The necessary work on cadavers was seen as grotesque, and dissection was something that ought to disgust the proper lady, the woman that met societal standards of behavior. While women physicians occupied this space, they also maintained a strong sense of feminine identity, often rejecting radical social movements—Elizabeth Blackwell was once invited to speak at a

⁴ Ibid.

women's rights convention, but declined as she felt men had been too instrumental in her development and career for her to denigrate them.⁵

Beyond redefining femininity by their actions, Blackwell and others also took up the pen, using a newly garnered professional authority and respect for expertise to dictate to the general public what femininity was by biological definition, and how it ought to be treated by society. Blackwell pushed for more rigorous education for girls, and wrote to describe how mothers could teach their adolescent daughters about sex.

This does not mean, however, that Blackwell was on the forefront of radical medical ideology—she maintained that disease had moral causes rather than bacterial ones and supported theories of eugenics; she opposed abortion and animal experimentation. Often as part of maintaining a strict and non-threatening feminine presence, women physicians frequently rejected theories and movements that could result in loss of support or public discredit.

The evolution of science also plays a large role in the narrative that I am investigating. The beginning of the time period I examine is marked by a grave uncertainty in medicine, with societal faith in physicians at an all time low, following news from Germany that the traditional treatments were not working in conjunction with a failure to find more successful treatment options. By the end of the relevant time period, we see the rise of statistical analyses, the increasing dependence on quantifiable measurements such as blood pressure and heart rate, and a decreased reliance on visual and qualitative data, as well as the emergence of fields such as microscopy, toxicology, and bacteriology. The rise in science also widens the knowledge gap between the doctor

⁵ Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Longmans, Green, and, 1895, 178-9.

and the patient, skewing the power dynamics of this relationship. As doctors grew more powerful, their authority was more readily accepted, allowing women physicians who may not have gained much traction from their male colleagues to gain ground with the wider population.⁶

Chapter One seeks to analyze the importance of medical education, with a focus on women's medical schools in particular. I will be focusing on the Women's Medical College of Philadelphia, the Medical College of the New York Infirmary of Women and Children (founded and overseen by Blackwell), and the New England Female Medical College in Boston. How were these institutions affected by the pluralism of ideologies that defined the medical profession in the nineteenth century? How were they received by the public, and by their future male colleagues? How did the standards of learning at a women's medical college compare to those of a men's medical college? I will go on to explore the role increasing government oversight, as highlighted by the Flexner Report, had on increased closings of female medical colleges. Finally, this chapter will examine the status of female medical students in coeducational medical schools—while coeducation was seen as the ultimate goal by many of the first generation of female physicians, did it really reflect genuine equality amongst medical students and professionals, regardless of gender?

Chapter Two seeks to investigate rhetorical strategies used by women physicians to explain why they were needed, what they brought to the field, and to counteract arguments made by their detractors. It first seeks to understand the arguments made against women physicians. These arguments had either a physical or moral basis. Male

⁶ Wells, Susan. *Out of the Dead House: Nineteenth-Century Women Physicians and the Writing of Medicine*. Madison: University of Wisconsin Press, 2001. 29.

physicians often said that women were not able to participate in medicine due to their physical frailty, for example. A separate line of argument claimed that women were unsuited for medicine due to their mental inability to think rationally. The popular science of phrenology, based on the analysis of the skull, was able to intertwine physical and mental aspects, as it dictated that development of certain areas of the skull resulted in the augmentation or diminution of certain mental and moral capacities. Phrenology was used by proponents and opponents of women physicians alike, and the differing interpretations advocated for their perspectives.

Chapter Three seeks to look at the role women physicians played in the profession as a whole. While many of the first wave of women physicians felt that their role was based on feminine moral exceptionalism, others felt that they should participate in the field in the same way that men did. Blackwell was a major proponent for maternalist medicine and felt that it was the role of women physicians to morally police the development of science. In opposition to her was Mary Putnam Jacobi, who felt that scientific evidence and rational thought should be dominant over moral instinct. Additionally, this chapter seeks to discuss the motivations women had for choosing to enter the profession. We will also investigate the actual experiences women had as well, as opposed to their ideal prescriptions. Finally, we will look at the ways in which women physicians used their professional authority to reframe gender. Some non-white female physicians also utilized their unique positions as intermediaries between the medical profession or the government or the middle class and their marginalized racial groups. While most women physicians at this time were white and middle-class, there were also a handful of black women physicians and at least one Native American woman physician. At a time at

which white doctors often let black patients die of tuberculosis without substantial treatment, due to the perception of increased susceptibility and weaker constitutions, how did early black female doctors address the ways in which black patients, male and female, were treated? Susan La Flesche Picotte was a physician and member of the Omaha tribe, and used her social status to provide a new way to view Native American populations, showing them as humanistic and civilized, while vocally opposing the means by which whites sold Native American alcohol, despite the high rates of alcoholism in the community.

Women continuously reified and subverted gendered expectations for their behavior. They drew a line between what was radical and acceptable, in terms of the profession, and what was radical and endangered the entire movement. By creating their own medical institutions, they were able to support each other and foster the especially feminine attributes they felt were crucially needed in the profession. By not refuting the differences between men and women, they were able to use phrenological arguments to justify their capabilities and their importance. By attaining professional authority, they were able to reformulate notions of gender such that subsequent women found it less difficult to enter the profession.

Chapter 1: Preconditions and Pathways for the Entrance of Women into Medicine:
Negotiating Women's Medical Education

In 1869, a group of women from the Women's Medical College of Philadelphia filed into a lecture hall at the Pennsylvania Hospital in Philadelphia. This was not, however, an innocuous address on medical practices, but instead a live hospital lecture on femoral fractures, complete with a male patient. This was the first recorded instance of women students attending clinical classes that were usually attended by men only.⁷ The momentary exposure of the patient's thigh, in order to explain the bone healing process, resulted in an outcry from the male students, who launched at the women "missiles of paper, tinfoil, tobacco-quids, etc."⁸ The women who reported on the incident noted the lack of decorum from their fellow students "while some of these men (?) defiled the dresses of the ladies near them with tobacco juice."⁹ This incident became known in the press as the Jeering Incident, and was discussed in local and regional newspapers.

Some of the newspaper editorials were defensive of the male students, claiming, "no person in female attire was hissed, booed, or insulted."¹⁰ The same author made the further claim that the female students "infest[ed] the rights of four-hundred regular medical students,"¹¹ and later asked "Who is this shameless herd of sexless beings who dishonor the garb of ladies?"¹² Reacting to what they saw as a clear violation of acceptable female behavior, the men in question and their

⁷More, Ellen S., Elizabeth Fee, and Manon Perry. "Introduction: New Perspectives on Women Physicians and Medicine in the United States, 1849 to Present." In *Women Physicians and the Culture of Medicine*, 3. Baltimore, MD.: Johns Hopkins University Press, 2009.

⁸ Skinner, Carolyn. *Studies in Rhetorics and Feminisms : Women Physicians and Professional Ethos in Nineteenth-Century America*. Carbondale, IL, USA: Southern Illinois University Press, 2014. Accessed September 12, 2015. 24. ProQuest ebrary. Women Physicians and Professional Ethos.

⁹ Marshall, Clara. *The Woman's Medical College of Pennsylvania: An Historical Outline*. Philadelphia, Pennsylvania: P. Blakiston, 1897. 20. The (?) was original to the primary source.

¹⁰ "Pioneers in the Face of Adversity: "The Mob of '69"" January 1, 1869. Accessed December 13, 2014. <http://doctordoctress.org/islandora/object/islandora:1347>

¹¹ Ibid.

¹² Ibid.

supporters stripped the women of their femininity, to exclude them both from the feminine and professional domains, to portray them as clear outsiders, and as violations of the laws of nature.

Numerous editorials written by anonymous female students defended their right to attend the lecture in peace.¹³ Interestingly, these editorials often questioned the gentlemanliness of the harassers, in the same way that supporters of the men questioned the femininity of the students. While both groups questioned each other's adherence to gendered expectations of behavior, neither questioned the rigidity of those expectations. This incident allows us to understand the difficulties early women medical students in nineteenth-century America faced in a coeducational learning environment. They confronted isolation, exclusion, harassment, and the harsh judgment of society. It is clear that while these women did challenge notions of gender by attending the lectures, they did not feel that way, and were deeply dissatisfied at being stripped of their femininity, which they felt was central to their claims of medical expertise.¹⁴

Early female medical colleges were places where women medical students could obtain a medical education without attacks on their femininity or their adherence to propriety. Early female medical students challenged gender boundaries, but often did so in ways that reified perceived gender norms. Early women doctors adhered to the argument that classically feminine traits such as

¹³ "Blackguardism." *Philadelphia Evening Bulletin*, November 8, 1869. Accessed October 15, 2014. <http://doctordoctress.org/islandora/object/islandora:1347>.

¹⁴ Morantz-Sanchez, Regina Markell. "Separate but Equal: Medical Education for Women." In *Sympathy and Science: Women Physicians in American Medicine*, 73. New York City, NY: Oxford University Press, 1985. 190.

empathy and compassion were in fact necessary attributes that women brought to medicine. Elizabeth Blackwell, for example, was very careful in selecting students for her medical school – rejecting anyone who seemed too radical in either their medical beliefs or social persuasion.¹⁵ Joseph Longshore, one of the founders of the Women’s Medical College of Philadelphia, argued that women were well equipped for the study and practice of medicine due to the “acuteness of her perception, correctness of her observation, her cautiousness, gentleness, kindness, endurance in emergencies, conscientiousness and faithfulness to duty.”¹⁶ Examining which qualities women’s medical education sought to accentuate and diminish can help us gain a broader understanding of the professional environment and education of early women physicians in the United States.

A woman’s introduction into the profession of medicine on an individual level was in medical school or training. While women had for generations studied medicine through apprenticeships to become midwives and later nurses and homeopathic doctors, I will be focusing on the institution of medical school.¹⁷ Having a formal medical education in a medical college that adhered to emergent national guidelines was instrumental in the struggle to earn legitimacy for these

¹⁵ Morantz-Sanchez, Regina Markell. "Separate but Equal: Medical Education for Women." In *Sympathy and Science: Women Physicians in American Medicine*, 73. New York City, NY: Oxford University Press, 1985, 73. Examples of candidates who were too radical believed in hydropathy and other homeopathic treatments and wore bloomers.

¹⁶ Longshore, Joseph. "The First Female Medical College: "Will You Accept or Reject Them?"" The First Female Medical College: "Will You Accept or Reject Them?" October 4, 1850. Accessed December 12, 2014. <http://doctordoctress.org/islandora/object/islandora:1496>.

¹⁷ Luchetti, Cathy. *Medicine Women: The Story of Early-American Women Doctors*. New York: Crown Publishers, 1998. 14-15.

women.¹⁸ Elizabeth Blackwell obtained her MD by studying at a male medical school. But this option did not exist for most aspiring women doctors. For example, following Blackwell's graduation at the top of her class, Geneva Medical College refused admission to subsequent female applicants. Emily Blackwell began studying at Rush Medical College in Chicago before she was asked to leave, ultimately completing her degree in Cleveland.¹⁹

Men in general, and male physicians especially, considered female physicians de-sexed. This was especially destructive to women doctors because they considered their femininity a critical part of what they had to offer. Early justifications from people such as Elizabeth Blackwell included the desire to instill a maternal, distinctly womanly aspect to medicine in the light of its hard-hearted reputation.²⁰ Before the advent and spread of anesthesia, physicians frequently had to consider how much pain to inflict on patients, constructing their reputations as cold and calculating, and bereft of the empathy and compassion early women physicians hoped to add to the profession.²¹ Virginia Penny, in her *Cyclopaedia of Women's Employment*, argued that the "mildness and amiability of woman, her modesty, her delicacy and refinement, all tend to make her acceptable at the

¹⁸ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 66, 75.

¹⁹ "Changing the Face of Medicine | Dr. Emily Blackwell." U.S National Library of Medicine. Accessed December 15, 2015.
https://www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_36.html.

²⁰ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 191.

²¹ Pernick, Martin S., and Ronald L. Numbers. "The Calculus of Suffering in 19th-Century Surgery." In *Sickness and Health in America*, edited by Judith Walzer Levitt, 98. Madison: University of Wisconsin Press, 1985.

bedside.”²² While Penny was promoting women’s employment, and as such was necessarily biased, this argument was also supported by others, including Elizabeth Blackwell and Joseph Longshore, one of the founders of the Women’s Medical College of Philadelphia.

Many of these early pioneers—the Blackwell sisters and Marie Zakrzewska, amongst others—became founders of and teachers at women’s medical colleges. While women’s medical colleges offered excellent medical education, they were marred by a continual, insidious fear of inferiority in comparison to male medical institutions.²³ They adhered strictly to the most recent regulations of the American Medical Association and often quickly and efficiently quashed any suspicions that homeopathy was a part of their curriculum. Despite the challenges confronting female medical colleges, they offered to their students something male-dominated and later coeducational medical colleges did not—a strong network of female professional and personal support.²⁴

In order to elucidate the importance of early female medical education, it will be essential to understand the general status of medicine at this time, in order to provide context regarding the profession. Next, a comparison of several women’s medical colleges will prove useful, with an emphasis on the Women’s Medical

²² Penny, Virginia. "Physicians." In *The Employments of Women: A Cyclopaedia of Woman's Work*, 15. Boston, MA: Walker, Wise, and Company, 1863.

²³ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 65.

²⁴ Tuchman, Arleen. *Science Has No Sex: The Life of Marie Zakrzewska, M.D.* Chapel Hill: University of North Carolina Press, 2006. 81.

For example, Elizabeth Blackwell helped initiate Marie Zakrzewska’s entrance into medical school, including sending her textbooks and fundraising for her tuition. Later, Zakrzewska moved into Blackwell’s home, and unable to find a landlord willing to let to a woman physician, opened a practice in her parlor.

College of Philadelphia, the Medical College at the New York Infirmary for Women and Children, and the New England Female Medical College. We must then examine how these institutions were received and how they kept up with American Medical Association guidelines and social conventions for medical education, as well as how students from these institutions were received by male doctors and medical students. I will also address the decline of exclusively female medical education, and the effects of coeducation on women physicians.

In 1848, there were no national standards of education required for medical licensing. Still, there were many medical schools. These early medical schools operated functionally as businesses, trying to ease access for consumers, in this case tuition-paying students. These proprietary medical schools held state charters and worked for profit. This meant that requirements were low, so that as many students as possible could qualify, with many only requiring a high school diploma for acceptance. Lest that be too stringent, however, especially in a time prior to the advent of public secondary education, they also accepted an ambiguous “equivalent.”²⁵ Once accepted, students attended a series of lectures over the course of a few months. Then, a year later, the same lectures would be heard a second time, and perhaps a dissertation written, and the student would go off for further hands-on training.²⁶ This training took the form of an apprenticeship with an established doctor, maintaining such traditional aspects of apprenticeship as paying for the

²⁵ Hudson, Robert P., and Ronald L. Numbers. "Abraham Flexner in Perspective." In *Health and Sickness in America*, edited by Judith Walzer Levitt, 148. 2nd ed. Madison: University of Wisconsin Press, 1985.

²⁶ Ibid.

opportunity to learn, and performing “repetitive, laborious, day-to-day work.”²⁷

Importantly, few women physicians were able to gain apprenticeships in the United States, either because they could not afford to pay their employers, or they were barred, as women, from such employment opportunities. Those who were able to acquire further training did so at women and children’s hospitals often run and founded by women. Elizabeth Blackwell’s New York Infirmary for Women and Children was one example of such an institution. It provided post-graduate training for Marie Zakrzewska, Mary Putnam Jacobi, and Rebecca Cole, an early black woman physician, among others.²⁸

Elizabeth Blackwell fought her way into this system of medical education. Upon entering her class, she was markedly more prepared than her average classmate, having trained with an anatomist and studied under a Dr. Allen in Philadelphia prior to medical school.²⁹ After completing the curriculum (taking the same lectures for two years), and graduating at the head of her class, Blackwell felt that her education was still insufficient for her to enter practice. Given the difficulty women faced in being awarded apprenticeships, Blackwell was advised that Europe was more open to women physicians. Prior to her admission to Geneva Medical College, she had been advised to dress as a man in order to obtain a medical

²⁷ Luchetti, Cathy. *Medicine Women: The Story of Early-American Women Doctors*. New York: Crown Publishers, 1998. 18.

²⁸ "Changing the Face of Medicine | Dr. Mary Corinna Putnam Jacobi." U.S National Library of Medicine. Accessed April 22, 2016.
https://www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_163.html.
Changing the Face pages

²⁹ Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Longmans, Green, and, 1895, 58-59.

education³⁰ While this may have resulted in Blackwell acquiring the medical knowledge she sought, she would have done so without bringing to the field the distinctly feminine traits she prized, the maternal instinct, care, and compassion she felt incumbent upon women to bring to medicine. This strategy did prove successful for Dr. Barry, a biologically female physician who spent her adult life disguised as a man (going by the name James rather than her birth name Miranda). She eventually became inspector-general of hospitals in the British army, and her true sex was found out only after her death.³¹ Blackwell, however, refused to disguise herself, as this was inimical to her reasons for becoming a physician. She wished to prove that women could be good physicians while maintaining traditionally feminine qualities. She also wished to remedy the poor reputation of “female physicians,” as the term was often used at the time as a euphemism for an abortionist.³² While she decided to go to Europe and studied in France and Britain, she refused to disguise her femininity. She obtained extensive clinical experience, particularly in obstetrics.³³ This began a pattern that was followed by her younger sister and a number of other female physicians, especially those wishing to specialize in a particular kind of medicine.

Barry and Blackwell provide an interesting contrast in the ways in which women approached medicine. While Barry clearly entered medicine despite her femininity, and renounced her feminine presentation for her entire adult life in

³⁰ Ibid.

³¹ Luchetti, Cathy. *Medicine Women: The Story of Early-American Women Doctors*. New York: Crown Publishers, 1998. 19.

³² Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Longmans, Green, and, 1895. 30.

³³ Ibid, 123.

order to do so, Blackwell refused to relinquish her femininity, as she felt that this was what uniquely qualified her and destined her to enter medicine. To understand her perspective, it is useful to revisit Blackwell's autobiography and examine her interest in medicine—it was not an interest in the scientific pursuit of medicine that motivated her to become a physician. Unlike the scientific advances made by Mary Putnam Jacobi and Alice Hamilton, Blackwell devoted her life almost exclusively to the care of female patients, both adults and children. She wrote about how mothers should educate their adolescent daughters about sex, how girls' education in general should be altered, and how girls should be raised. In fact, Blackwell admitted to an initial revulsion to the human body and the study of anatomy in her *Pioneer Work*.³⁴ Still, Blackwell was drawn to medicine, despite her misgivings, after a terminally ill family friend informed her that her worst sufferings would have been alleviated by having a female physician.³⁵

We do not have comparable information on Barry. This makes sense, of course, given that she lived her entire adult life as a man, with the discrepancy between her biological sex and her presentation being made public only after her death. Barry served in the military as a surgeon. Descriptions of Dr. James Barry described him as abrasive and aggressive. Barry was known to have participated in a duel “and sought many more,” demonstrating an aggression that would have likely been seen as classically masculine.³⁶ These qualities seemed incongruous with the

³⁴ Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Source Book Press, 1895, 27.

³⁵ Ibid.

³⁶ Loudon, I. "Book: Scanty Particulars: The Strange Life and Astonishing Secret of Victorian Adventurer and Pioneer Surgeon James Barry." *BMJ* 324, no. 7349 (2002): 1341. doi:10.1136/bmj.324.7349.1341.

presumed virtues of femininity extolled by Blackwell and other early supporters of female physicians. Nonetheless, while Barry eschewed a classically female presentation, she did participate in reform work and aid of underserved populations, in much the same way that Blackwell would in New York. While Blackwell's New York Infirmary for Women and Children served poor women and children in New York City, Barry led prison reforms and offered medical treatment to lepers in Cape Town, South Africa.³⁷

Of course, Blackwell was not the only openly feminine woman receiving a medical education at this time and in 1850 the Women's Medical College of Philadelphia (originally named the Female Medical College of Philadelphia) was founded.³⁸ The initial faculty of this institution leaned rather heavily towards homeopathic treatments, which contributed towards the school's poor reception amongst other medical professionals in Philadelphia. C.N. Prince wrote to Clara Marshall that "so intense was the feeling on the part of the profession against the men who were willing to accept professorships in the school or give instruction to women, that it was with difficulty that good teachers could be obtained."³⁹ This suggests that only those who were already marginalized in the profession to some extent, likely due to their homeopathic views, would have chosen to teach at the college.

³⁷ Loudon, I. "Book: Scanty Particulars: The Strange Life and Astonishing Secret of Victorian Adventurer and Pioneer Surgeon James Barry." *BMJ* 324, no. 7349 (2002): 1341. doi:10.1136/bmj.324.7349.1341.

³⁸ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 76.

³⁹ Marshall, Clara. *The Woman's Medical College of Pennsylvania: An Historical Outline*. Philadelphia, Pennsylvania: P. Blakiston, 1897. 12.

Homeopathy was more open to women than ‘regular’ or allopathic medicine was, partially due to alternative pathways of training—apprenticeships rather than formal medical school could be sufficient for a homeopath to set up a practice. Additionally, sectarian medical schools were more frequently coeducational than their regular allopathic counterparts. For example, Chicago’s Bennett College of Eclectic Medicine and Hahnemann Medical College were both open to women students before the regular Chicago Medical College.⁴⁰ It was also more receptive to a group marginalized for their sex because within the profession, homeopaths were also ostracized, their beliefs considered ‘quackery’ by many regular physicians. It was not uncommon to see husband and wife in practice together, starting hydropathy clinics or practicing other forms of homeopathic medicine. Some women had obtained apprenticeships without having been to a formal medical school.

Until recently, there was comparatively little interest in the study of sectarian or homeopathic female physicians. In light of recent research, however, some historians argue that “sectarian medical schools helped provide women with access to medical education before women’s medical schools existed,” despite a continued belief that women’s medical colleges were the major avenue for women’s medical education.⁴¹ It is also interesting to note that while most regular female physicians graduated from an all-female medical school, most of their female sectarian counterparts graduated from coeducational institutions, such as Penn Medical

⁴⁰ Fine, Eve. “Women Physicians and Medical Sects in Nineteenth-Century Chicago.” In *Women Physicians and the Cultures of Medicine*, 249. Baltimore, MD: Johns Hopkins University Press, 2009.

⁴¹ Ibid, 246.

University and Cleveland Medical College.⁴² Eve Fine uses Chicago as a focal point for the comparison of sectarian and regular women physicians. In the city of Chicago, there were no requirements to enter into medical practice until 1878, making the field there open to alternative medical beliefs and practices. The first women's medical college in Chicago opened in 1871. Before this, most of the city's women doctors were sectarians.⁴³

It seems clear, then, that women seized the opportunity offered by this slightly more permissive subset of medical practitioners. It was a group of men with homeopathic leanings who went on to found and teach at the Women's Medical College of Philadelphia. However, once the college was sufficiently established, the school gradually turned away from homeopathic training over the course of ten years in favor of 'regularizing' the college, after which none of the original faculty remained at the college. This was a move aimed at improving the reputation of the school and adhering to its policy of regular, minimally-controversial medical education. The change was not as extreme as it sounded—some of the new professors were recent graduates of the college, taught by the same homeopathy-sympathizing professors they replaced. Susan Wells describes the WMCP's early efforts to maintain regular medicine in the face of homeopathy as "a constant struggle, seldom explicit, to limit professorships to regular rather than Eclectic doctors."⁴⁴ In part, this shift was the consequence of the rise of allopathic medicine

⁴² Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 76, 93.

⁴³ *Ibid*, 246.

⁴⁴ Wells, Susan. *Out of the Dead House: Nineteenth-Century Women Physicians and the Writing of Medicine*. Madison: University of Wisconsin Press, 2001. 127.

and decline of sectarian practitioners. Homeopathy, though a more open pathway for women to practice medicine, was increasingly marginalized by the allopathic, or regular, medical community. Women physicians, already ostracized by a large portion of the profession, sought to address the possibility of further marginalization by adhering to current trends in medical education.. Women's medical colleges were already necessarily controversial in terms of the students they taught – their goal was to be minimally controversial in other aspects, including the techniques and ideologies they subscribed to.

Joseph Longshore is one of the best examples of this. A notable homeopath, he was one of the founders of the WMCP.⁴⁵ His sister-in-law Hannah Longshore was one of the college's earliest graduates, and found herself somewhat divided from her fellow alumnae following graduation due to her continued homeopathic sympathies.⁴⁶ Within a few years of the school's founding, Longshore found himself ousted. He went on to found the Pennsylvania Medical University, a coeducational sectarian medical school, after leaving the WMCP.⁴⁷

But why did this happen? These physicians, homeopathic or not, clearly demonstrated a belief in and support for women's medical education at a time and place where such support was rare. It seems counterintuitive to remove many of these men when they had been instrumental in opening the college in the first place, at great personal and professional cost – losing the recognition of the profession at large, particularly that of regular physicians. In order to answer this question, we

⁴⁵ Wells, Susan. *Out of the Dead House: Nineteenth-century Women Physicians and the Writing of Medicine*. Madison: University of Wisconsin Press, 2001, 122.

⁴⁶ Ibid.

⁴⁷ Ibid, 128.

must examine attitudes towards women's medical education, focusing on the attitudes of women going through these programs themselves and the opinions of their male colleagues.

Antebellum medical education consisted mainly of proprietary medical schools operating with little intervention or supervision from the state. Licensing requirements varied from state to state, but most had had no formal licensing requirements that schools had to adhere to. So schools could, in addition to having few requirements, make medical education fairly quick and easy—the same set of fifteen or so lectures given two years in a row for a few months of the year, an optional thesis, and graduation was practically guaranteed.⁴⁸ In 1834, Elizabeth Blackwell's alma mater Geneva Medical College had professors of chemistry, anatomy and physiology, "the Institutes and Practice of Medicine," the "Principles and Practice of Surgery," obstetrics and materia medica, and medical jurisprudence and botany.⁴⁹ During her first year of study at the University of Michigan College of Medicine in 1890, Alice Hamilton studied "obstetrics and gynecology, the theory and practice of medicine, surgery, materia medica (pharmacology) descriptive and surgical anatomy, physiology, embryology, chemistry, toxicology, and urinalysis."⁵⁰ Shifts in education were evident, as much of Hamilton's instruction was in the

⁴⁸ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 68-69; Hudson, Robert P. "Abraham Flexner in Perspective: American Medical Education, 1865-1910." In *Sickness and Health in America*, edited by Judith Walzer Leavitt and Ronald L. Numbers, 148. Second ed. London: University of Wisconsin Press, 1985.

⁴⁹ *Circular and Catalogue of the Faculty and Officers of the Medical Institution of Geneva College*, Geneva, New York, September 1834. Oliphant & Skinner, Auburn. (accessed at SUNY Upstate Medical University Archives, August 4, 2015).

⁵⁰ Sicherman, Barbara, and Alice Hamilton. *Alice Hamilton, a Life in Letters*. Cambridge, Mass.: Harvard University Press, 1984. 36.

laboratory where little of Blackwell's had been, forty-two years earlier.⁵¹ We also see curricular differences – Hamilton studied chemistry, toxicology, and urinalysis, none of which were taught when Blackwell had been in school.

The lax nature of medical education at this time meant that all types of students could enter, and could either study with passion and devotion, or go to class during the day and the beer-saloon at night, and graduate with equivalent credentials. Society began losing respect for the medical profession as a whole upon seeing this behavior. Citizens of Geneva, New York, for example, often complained of the disturbance caused by the medical students there. One of the most remarked-upon aspects of Elizabeth Blackwell's time there was her success in unintentionally influencing the behavior of her rowdy classmates, but simply by her presence. Women often argued that their civilizing influence was a major reason they should be not only allowed, but encouraged to study medicine.

Additionally, news coming out of France and Germany provided scientific evidence that commonly used medical treatments were ineffective.⁵² Prior to this revelation, doctors were generally trusted to heal patients, and were seen as having the authority to do so.⁵³ However, after the public learned that the methods they had been treated with for so long were not in fact helping them, doctors lost that

⁵¹ Ibid; *Circular and Catalogue of the Faculty and Officers of the Medical Institution of Geneva College*, Geneva, New York, September 1834. Oliphant & Skinner, Auburn. (accessed at SUNY Upstate Medical University Archives, August 4, 2015)

⁵² Hudson, Robert P. "Abraham Flexner in Perspective: American Medical Education, 1865-1910." In *Sickness and Health in America*, edited by Judith Walzer Leavitt and Ronald L. Numbers, 148. Second ed. London: University of Wisconsin Press, 1985.

⁵³ Rosenberg, Charles E., and Ronald L. Numbers. "The Therapeutic Revolution: Medicine, Meaning and Social Change in 19th-Century America." In *Sickness and Health in America*, edited by Judith Walzer Leavitt, 39-50. Madison: University of Wisconsin Press, 1985.

authority. By the 1830s, there was no longer commonly accepted proof backing a single medical ideology, and so many new branches of medicine with divergent philosophies arose. Some of these included mesmerism, magnetism, Thompsonian medicine, hydropathy, and homeopathy.⁵⁴ These departures from traditional, or allopathic, medicine, were called sects, and fell under the umbrella of sectarian medicine. The opening of the field allowed ideological pluralism to grow in medicine. This resulted in homeopathic physicians such as Longshore and his colleagues opening medical colleges. As these nontraditional groups grew in numbers and popularity, they posed a greater threat to traditional, or allopathic, physicians. Traditional practitioners disliked these new disciplines first because they differed from what they considered true medicine to be, and second because of the economic competition that they created. Dislike and distrust of homeopaths continued as women gained entry into medicine, something the founders and graduates of the WMCP experienced first hand. Likewise, one of the reasons supporters urged Elizabeth Blackwell to open a medical school attached to her New York Infirmary for Women and Children was in order to prevent female students from going to New York Medical College for Women, a sectarian institution. Furthermore, as applicants arrived for her school, Blackwell (as well as her sister and German-born Marie Zakrzewska) was highly selective in the students who were selected. Zakrzewska referred to some applicants as “extremists,” and discussed hydropaths who were turned away because “popular prejudices could be overcome

⁵⁴ Ibid.

only in the most careful and conservative manner.”⁵⁵ This meant that women who favored hydropathy were refused, as were women wearing “very short Bloomer costume, with hair cut very short.”⁵⁶ So women who were noticeably radical, either in dress or in medical beliefs were turned away from clinical practice.

During the second half of the nineteenth century, when the general practitioner was still highly respected, before specialists rose to higher social status within the profession and within society in general. General practitioners, as defined by historian Irvine Loudon, held qualifications in both surgery and medicine. At this time, more surgical procedures were being replaced by medical treatments, so it was advantageous to be familiar with both, to the extent that those who specialized in a particular organ were seen as “men who had failed in the general fields of physic or surgery and were forced to set up as specialists in order to attract business.”⁵⁷ Loudon adds an additional dimension of competition to medical practitioners: not only were ‘regular’ physicians competing with various branches of osteopaths, but general practitioners were also competing against surgeons and physicians. Loudon describes “an age that admired breadth of knowledge rather than narrow specialization,” which can help explain why women physicians such as Elizabeth and Emily Blackwell, and numerous contemporaries, sought training in various fields of medicine rather than choosing to hone in on a specific area.⁵⁸

⁵⁵ Morantz-Sanchez, Regina Markell. "Separate but Equal: Medical Education for Women." In *Sympathy and Science: Women Physicians in American Medicine*, 73. New York City, NY: Oxford University Press, 1985, 73.

⁵⁶ Ibid. Morantz-Sanchez quotes Zakrzewska here.

⁵⁷ Loudon, Irvine. *Medical Care and the General Practitioner, 1750-1850*. Oxford: Clarendon Press, 1986. 189-191.

⁵⁸ Ibid.

Women medical students, in fact, often pursued a more rigorous course of study before entering medical school. This served to prove that women in general could accrue scientific knowledge, and were tough enough to study subject matter that was considered grotesque, which helped defeat the primary arguments against women studying medicine– that women were incapable of rational thinking and were too delicate to study the human body. Elizabeth Blackwell had studied under several physicians and an anatomist, and had done dissections before even stepping foot in a medical classroom. Alice Hamilton, who entered the Fort Wayne College of Medicine, did so in 1890 (over forty years after Blackwell), having previously studied chemistry and physics with a high school teacher and having “worked biology in Fort Wayne and Mackinac.”⁵⁹ Her academic excellence was recognized by her professors, and was rewarded by supplementary work and the opportunities to assist in operations and prescribe medicine for charity patients (the latter was sometimes accompanied by a fee.) Mary Putnam Jacobi already had a degree from the New York College of Pharmacy before entering the WMCP to attain her first medical degree, and then later traveling to France to further her training.⁶⁰

A similar sort of mentality can explain the turnover seen a few years after the founding of the Women’s Medical College of Philadelphia, as well as the constant desire for coeducation and the continual fear, propagated by male physicians, that female-only medical schools would be less thorough than male-dominated ones. The

⁵⁹ Sicherman and Hamilton, 34-35.

⁶⁰ "Changing the Face of Medicine | Dr. Mary Corinna Putnam Jacobi." U.S National Library of Medicine. Accessed December 15, 2015.
https://www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_163.html.

Blackwells' medical college, opened in 1868, had a more rigorous curriculum than most other schools, requiring three years, obligatory hospital training alongside lecture-based education, and a total of ten professors (three of whom were female).

Occasionally, the AMA made recommendations on different aspects of medical education—the size of medical schools, the length of terms, and the rigor of examinations, for example. Because there was little government oversight, and the AMA itself had little power to enforce these recommendations, most schools were slow to adhere to them. In 1867, just before the Blackwell sisters opened their school, the AMA released a new report recommending a graded curriculum, yearly examinations, and a faculty of at least nine professors. In 1874, the AMA recommended that medical colleges have terms of six and a half months for three years of study, with more rigorous academic background, dissection, and clinical experience, at schools with at least seven professors.⁶¹ Women's medical colleges were some of the first to adjust to new AMA recommendations. This rapid adaptation to changing definitions of adequate and rigorous medical education was reflective of the desire of women's medical schools to avoid lowering their standards.

In addition to these pressures, there was also a sense that women's medical schools simply didn't prepare their students for medical practice. While graduation from the WMCP or another women's medical college (there was another in New England) gave women the legal right to practice medicine, there was a general

⁶¹ Morantz-Sanchez, Regina Markell. "Separate but Equal: Medical Education for Women." In *Sympathy and Science: Women Physicians in American Medicine*, 73. New York City, NY: Oxford University Press, 1985, 74-75.

opinion that this wasn't quite good enough – Blackwell was one of many women who advocated a practical education in Europe, declaring it was “almost impossible for a lady to get a *good* medical education without going to Europe,”⁶² where students could build firsthand knowledge through extensive case observations and ward rotations. Mary Putnam Jacobi, Emmeline Cleveland, and Emily Blackwell (Elizabeth's younger sister) were notable examples of other women who pursued a practical European education following their graduation. This persisted until Blackwell opened her own hospital, which then saw many new graduates train domestically. When she was unsatisfied with their educational backgrounds, she proceeded to add a medical college to the hospital. Even when the education itself was ‘good enough,’ i.e. comparable to that received from a male medical college, there remained a continuing insidious fear of women graduates. This directly shaped strict educational standards upheld in women's medical colleges. Historian Regina Markell Morantz-Sanchez argues that “most women physicians clung to a belief in the necessity of coeducation largely because they doubted women's ability to create separate institutions commensurate with male standards.”⁶³ Until coeducation was made available, women doctors faced the reality that the onus to provide women with medical education rested on them and on any male colleagues sufficiently sympathetic to the cause, and even then these institutions were often perceived as insufficient institutions of medical training—regardless of the high standards of their curriculum.

⁶² Penny, Virginia. "Physicians." In *The Employments of Women: A Cyclopaedia of Woman's Work*, 25. Boston, MA: Walker, Wise, and Company, 1863.

⁶³ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 85.

Whatever reputé female medical colleges did garner—good and bad—often hinged on the reputations of their founders. The New England Female Medical College in Boston was founded by Samuel Gregory, a health reformer who had no formal medical education. Gregory was outraged by the fad of male midwives and saw them as offensive to feminine modesty and delicacy, and so began a school for female midwives. This school, founded in 1848, got a new charter in 1856 as a female medical college. A number of influential women’s rights activists aided in its funding. Soon, Marie Zakrzewska, one of Elizabeth Blackwell’s handpicked protégées and friends, was teaching there. Despite a promising start, the school soon faltered. Zakrzewska left shortly after joining the faculty, finding that Gregory’s medical conservatism, resistance to new technology and domineering personality were ruining the reputation of the school and fearing the destruction could destroy not only of her own career, but also of the entire movement of women in medicine.⁶⁴ Morantz-Sanchez argues that the politicization of the school without scientific or professional backing was one of the main reasons that it was not academically rigorous, and did not earn the reluctant acceptance that the WMCP and Women’s Medical College of the Infirmary of New York eventually were able to.⁶⁵ When activists like Gregory with no medical experience started interfering with medical education for women, they often risked the venture as a whole and were censured not only by opponents of women in medicine, but also by male and female

⁶⁴ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 80-82.

⁶⁵ *Ibid*, 81.

doctors alike, including Zakrzewska and Mary Putnam Jacobi, two of Blackwell's former students.

Despite the negative attention attracted by Gregory's institution, his outrage at male midwifery or belief in feminine delicacy were shared by many proponents of female physicians. These ideas were in fact central to the argument women doctors were making in defense of their role in the profession. Societal propriety dictated that women practice modesty and delicacy, and encouraged discretion in discussions of issues defined as gendered and thus of a sensitive nature: pregnancy, childbirth, breast cancer, and reproductive disorders, to name but a few. Even eye problems and other symptoms that are no longer associated with the patient's sex were characterized as gendered disorders at this time. One of the most famous examples of this was Blackwell's family friend. It is critical to note that this was in no way an isolated case. Women with health problems frequently died due to reluctance to disclose symptoms to a man. It was also commonly believed that men misdiagnosed women, being unable to fully understand women's diseases in the way a woman would be able to.⁶⁶

When one compares the New England Female Medical College to the Women's Medical College of Philadelphia, founded by a group of Quaker men notably including Joseph Longshore, we can compare the different ways in which the institutions reacted to criticism of the quality and content of their education. When Longshore and his colleagues' homeopathic beliefs began damaging the credibility of the institution and its graduates, they were gradually removed and

⁶⁶ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 210.

replaced with female graduates.⁶⁷ In this way, the WMCP saved itself from the type of infamy earned by its Bostonian counterpart. Elizabeth Blackwell's Women's Medical College of the Infirmary of New York never risked losing its credibility as an institution of medical education, as Blackwell's rigidly regular opinions and incredibly severe examinations were renowned. Blackwell also had powerful connections, both in America and in England, who were widely respected and wealthy enough to ensure that her school never suffered under the dire economic straits of its cousins in Philadelphia and other cities. This allowed her to protect her own institution from the harsh scrutiny faced by other women's medical colleges like the WMCP, despite their academic rigor.⁶⁸

It is important to reflect on the differences between the WMCP and the New York Infirmary Medical College, the more successful and respected women's medical colleges I've chosen to focus on. Blackwell started her school in response to prompting from people and to prevent women from entering homeopathy instead. She built it after the WMCP had already been established. There were also differences in financing – the WMCP initially had very little money, while Blackwell was backed by a number of donors, and had connections with a number of influential people. Despite the difference in financial backing, the Women's Medical College of Philadelphia and other female medical colleges updated their curricula within just a couple of years of Blackwell's school, and often well ahead of the AMA's

⁶⁷ Wells, Susan. *Out of the Dead House: Nineteenth-Century Women Physicians and the Writing of Medicine*. Madison: University of Wisconsin Press, 2001. 62.

⁶⁸ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 76.

mandatory curricular changes.⁶⁹ Rising standards of education in women's medical colleges were matched by rising standards of entrance. Students entering the WMCP were required to present a diploma or take an entrance exam in 1871. The WMCP and the New York Infirmary were two of the six schools to require a four-year course by 1893, well before being mandated to do so.⁷⁰

Medical education changed in the wake of the Civil War, as land grant institutions arose, and had coeducation in their charters. Many of the first institutions to accept women were therefore newly founded. Other schools were forced to accept women due to financial constraints, a notable example being Johns Hopkins. While the main donor and namesake of Johns Hopkins was incredibly wealthy, money had run out by the time the medical school was created. Furthermore, investments in the Baltimore and Ohio Railroad, which were expended to fund the medical school, did not profit as much as expected.⁷¹ A group of wealthy Baltimore women whose fathers were trustees, started a nationwide committee to fund the medical school, and these funds were given only under the condition of coeducation. One of the most generous donors gave money under the condition of high admissions requirements, and consequently Johns Hopkins was the first medical school to require a bachelor's degree prior to entrance.⁷²

With the rise of coeducation came the very rapid demise of exclusively female medical education. Morantz-Sanchez attributes the closing of female medical

⁶⁹ Ibid.

⁷⁰ Ibid.

⁷¹ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 86.

⁷² Ibid, 83-87.

schools partially to “mounting financial burdens engendered by the costs of medical education in a new scientific age,” as well as the hope that coeducation would be able to take over.⁷³ The network of female physicians that had allowed for rapid growth early on deteriorated, as fewer women’s institutions were open, and students increasingly chose to study at coeducational institutions. Still, though the doors of the facilities were now open to some women, their experiences were nonetheless quite difficult. Subsequent female physicians often felt more isolated. The number of applicants and graduates also decreased, as medical colleges often instituted official and unofficial quotas on how many female students they would accept, often around 5% of matriculants.⁷⁴ Examples of this include Harvard and Stanford, among others.⁷⁵ By the 1890’s, however, more women studied in coeducational medical schools, sometimes making up a large percentage of the graduating class. For example, Alice Hamilton’s graduating class from the University of Michigan, where she studied after leaving the Fort Wayne College of Medicine, consisted of an unusually high proportion of female students, (fourteen out of forty-seven graduates).⁷⁶ However, even at allegedly coeducational institutions such as Michigan, classes were often segregated, and many schools continued to exclude women students from urology clinics.⁷⁷ Coeducation also resulted in the loss of the

⁷³ Ibid, 87.

⁷⁴ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 86.

⁷⁵ "Overview of Women Physicians in the United States." In *Women in Medical Education: An Anthology of Experience*, edited by Delese Wear, by Leah J. Dickson, 4-5. New York: State University of New York Press, 1996.

⁷⁶ Sicherman and Hamilton, 34.

⁷⁷ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 71.

network of support that had been generated in female medical colleges and the broader woman physician community.

So did the meteoric rise of women physicians occur after the impediments to medical education had been technically removed? No, despite the hopes of early pioneers such as Elizabeth Blackwell and Mary Putnam Jacobi, who felt that coeducation would be the key to completely integrating women into the profession. While some schools continued to refuse to admit women entirely, others took women as up to (and no more than) 10% of their matriculants. This is particularly notable in light of the fact that women applicants were on the whole more qualified than their male counterparts – Dean Meyers of Indiana University admitted that “a higher percentage of women who present themselves for matriculation in medical schools are well prepared for the study of medicine.”⁷⁸ There was also a shift as medical schools began placing size limits on their classes rather than accepting all qualified students, which made admission more competitive. In the light of the institutional discrimination displayed by many of these medical schools, it became even harder for qualified female applicants to gain admission.

There were also other factors at play that limited the number of women medical students. While all-female medical schools had closed down, and others had opened their doors to men and women in unequal measure, the nature of medical education itself also changed, as requirements for applicants became more stringent. More and more schools required a bachelor’s degree upon entry, and medical education began to include an internship and residency following

⁷⁸ Ibid, 331.

graduation, leading to a very lengthy and highly structured process for women to undergo. Additionally, fewer women were financially supported in the way that their male colleagues were – often families did not want to pay for the medical education of daughters, while they would be willing to do so for sons. Fewer women could work to support their medical education as costs rose. Additionally, at a time when more and more women were choosing to marry, and often dropping their professional careers because of it, fewer women were choosing medicine.⁷⁹ This issue of marriage caused divisions amongst female professionals – among physicians especially, some women believed that physicians should not marry, but be devoted to their profession, while others believed it was completely possible to have both. Nonetheless, the burden of caring for the household and the children usually resulted in some sort of professional cost, unless full-time servants and child-care workers were enlisted, as was often the case.

The argument could be made that the situation of declining female participation was not unique to the field of medicine, but rather a consequence of evolving ideas of feminism, femininity, and views regarding one's household responsibilities. This argument is quickly disproven, however, when a comparison is made with other professions – the number of women in law school doubled and those receiving PhDs tripled while enrollment of women in medicine increased by only 16.7% (as compared to the 59% increase in male enrollment).⁸⁰

⁷⁹ Ibid, 322.

⁸⁰ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985, 314.

This shows that coeducation was not the solution to complete integration that Elizabeth Blackwell and others hoped it would be. In fact, it seems that women in medicine actually regressed in comparison to women in other fields with comparable schooling, such as law and PhDs in various subjects, as well as in comparison to men in medicine.

Female medical education was crucial in ensuring that women physicians did not have to relinquish their femininity in order to pursue the profession, an important point as many of these early women physicians felt their feminine attributes were a crucial part of what they offered to the profession that their male colleagues did not. It also provided a framework of personal and professional support for these women physicians at a time when they were often marginalized in the eyes of society at large.

Not all female medical schools were received positively, as demonstrated by Samuel Gregory's New England Female Medical College. However, when the medical schools demonstrated their adherence to traditionally accepted medical methodology through updated curricula, they were able to earn the reluctant respect of the medical community. In order to maintain that respect, however, female medical schools often held themselves to a more rigorous standard than their male counterparts, who had nothing to prove. This difference in standard was reflected in differences in testing difficulty between Elizabeth Blackwell's Medical College of the New York Infirmary for Women and Children and nearby male medical schools.

Following the Civil War and subsequent opening of medical schools to women, exclusively female medical education diminished, accelerated by the growing financial burdens of increasingly scientific and laboratory-oriented coursework. Coeducation, while a clear goal of the first generation of female medical doctors, did not prove to be a mechanism to catalyze complete integration of female physicians into the profession, as medical schools continued to treat male and female students differently, whether by segregating classes, rejecting qualified female candidates while accepting less qualified male students, or by maintaining official or unofficial quotas on the proportions of female students admitted.

Chapter Two: Investigating Rhetorical Strategies of Opponents and Advocates of Women Physicians

The purpose of this chapter is to examine first, the arguments against women physicians, and secondly, how women physicians used rhetorical strategies to counter opposition and change the way in which women were perceived. In order for their words to have resonance and be taken seriously, female physicians constructed their professional authority. Therefore, we must also examine the importance of this authority and the ways in which women physicians asserted it. Physicians, both male and female, used rational and scientific reasoning to demonstrate their expertise, but women also used this rhetoric as a counter to the argument that femininity and scientific learning were incompatible. Advocates for women physicians often relied on the same implicit assumptions about gender as their detractors, and turned this into a strength—women were naturally empathetic they argued, and could, through medical training become excellent physicians. Men on the other hand, lacked any means to alleviate the same gender norms that presumed the impropriety of a physically examining female patients. Examining the arguments posed by critics of female women physicians as well as the ways in which female doctors and their advocates refuted those arguments will allow us to better understand social conceptions of femininity, the rise of medical professionalism, and the perceived incompatibility between the two. We will also be able to see which qualities or aspects of femininity women physicians sought to emphasize or erase in an attempt to seem more suited to the pursuit of science and professional authority.

There were a number of common threads seen in different arguments that opposed the entrance of women into medicine. Broadly speaking, these can be

placed in three categories: biological, moral, and social. Biological arguments claimed that increased intellectual exertion of any kind, not just in medicine, would result in atrophy of the reproductive organs. Proponents of biological arguments also argued that women's gender specific health would negatively affect the profession. Moral arguments, on the other hand, focused on character weaknesses of women, such as an inability to think rationally and scientifically, and focused on mental fragility as an insurmountable obstacle to their success. Finally, social arguments discussed the inevitably ruinous consequences to communities and society more broadly of women abandoning their homes, husbands, and children, in pursuit of their profession. Women physicians used a combination of scientific argument, classical gender roles, and adherence to Victorian values of modesty and privacy to counter these arguments.

It was thought, for example, that over-education and over-development of the female brain during puberty would result in improper development of the female reproductive organs. To protect their health and adequately perform their social responsibility of reproduction, such arguments maintained, women should avoid not only the practice of medicine, but also participation in all other intellectually demanding endeavours.¹ This argument rested on the assumption that the body was a closed system of energy. If more energy was focused on intellectual development, then it had to be taken from somewhere. For women, it was assumed, the energy was drained from one's reproductive organs. Following the deterioration

¹ Edward H. Clarke. *Sex in Education, or a Fair Chance for Girls*. Boston: Houghton, Mifflin, and, 1884. Smith-Rosenberg, Carroll, and Charles Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *Women's Bodies*. doi:10.1515/9783110976328.40. 339.

of the reproductive organs, the woman “would become weak and nervous, perhaps sterile, or... capable of bearing only sickly and neurotic children.”² In this way, intellectual pursuits endangered not just women, but also perhaps, society more broadly.

From the beginning of the nineteenth century, physicians and scientists were also interested in the perceived difference between American women and English or European women, arguing that the former were physically inferior.³ This difference was often attributed to the fact that American women were educated with boys, and increasingly demanded access to higher and even professional education. Male physicians in the 1870s feared that the educational activism would only lead to a further degeneration of American women.⁴ Because such arguments were made by physicians, they were granted authority by the general public. These arguments often reinforced the belief, mentioned in the previous chapter, that the study of medicine unsexed women. If the female sex was defined by reproductive organs, their degeneration necessarily resulted in the deterioration of feminine nature. Edward H. Clarke addressed this in his 1875 pamphlet *Sex in Education; or a Fair Chance for Girls*. Clarke posited the idea, originally part of Herbert Spencer’s theory, that the body is a closed system, and so education, particularly during female adolescence, posed a serious threat to the development of a healthy reproductive system:

The system never does two things well at the same time. If the schoolmaster overworks the brains of his pupils, he diverts force to the brain that is

² Ibid. 340.

³ Ibid, 339.

⁴ Ibid, 340.

needed elsewhere. He spends in the study of geography and arithmetic, of Latin, Greek and chemistry, in the brain-work of the school room, force that should have been spent in... growth. The results are monstrous brains and puny bodies; abnormally active cerebration, and abnormally weak digestion; flowing thought and constipated bowels; lofty aspirations and neuralgic sensations... Previously to the age of eighteen or twenty, opportunity must be periodically allowed for the [development of the reproductive system]. Both muscular and brain labor must be remitted enough to yield sufficient force for the work. If the reproductive machinery is not manufactured then, it will not be later. If it is imperfectly made then, it can only be patched up, not made perfect, afterwards... Force must be allowed to flow thither in an ample stream, and not diverted to the brain by the school, or to the arms by the factory, or to the feet by dancing.⁵

Clarke concluded that while it was possible for men and women to attain the same knowledge, men must learn in one way, and women in another. As the argument went, men grow at a steady pace, whereas female adolescence required focused energy for the development of the reproductive system.

Another prevalent biologically-based argument held that women, who were considered naturally frail and more susceptible to illness, needed medical care more frequently than men, and thus, that the demanding profession of medicine would weaken their health. This was considered the consequence of both the closed-system argument mentioned above, as well as the physical demands of the medical profession. The pressure of competition, with both their male and female peers, left the female college student susceptible to “hysteria and neurasthenia.”⁶ Edward Clarke argued that women could study just as effectively in colleges designed for men, but could not at the same time “retain uninjured health and a future secure

⁵ Edward H. Clarke. *Sex in Education; Or, a Fair Chance for Girls*. Accessed via Project Gutenberg.

⁶ Smith-Rosenberg, Carroll, and Charles Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *Women's Bodies*. doi:10.1515/9783110976328.40. 341.

from neuralgia, uterine disease, hysteria, and other derangements of the nervous system.”⁷

Men and women were seen to be intrinsically, physically different, with the female body “frailer, her skull smaller, her muscles more delicate.”⁸ The second of these criticisms, that of a smaller skull, was especially convincing at the time, given the popularity of phrenology. This scientific ideology argued that skull shape and size was reflective of intrinsic differences in capability and intelligence. Phrenology was based on the idea that the brain was the organ of the mind and that the skull was shaped uniquely to accompany the brain, which allowed for the detection of intellectual capabilities and personality traits through precise skull measurements.⁹ Its widespread acceptance, both popularly and scientifically, led many critics of female physicians to use phrenology as explanation for the supposed inferiority of not only women, but also non-whites. Students of phrenology argued that the measurable differences in the female skull’s demonstrated that women were “far more sensitive and susceptible than the male, and extremely liable to those distressing affections which for want of some better term, have been denominated nervous, and which consist chiefly in painful affections of the head, heart, side, and indeed, of almost every part of the system.”¹⁰ In other words, the natural delicacy that characterized women could be measured and reified by phrenology.

⁷ Edward H. Clarke. *Sex in Education; Or, a Fair Chance for Girls*. Accessed via Project Gutenberg.

⁸ Smith-Rosenberg, Carroll, and Charles Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *Women's Bodies*. doi:10.1515/9783110976328.40. 334.

⁹ Bittel, Carla. "Woman, Know Thyself: Producing and Using Phrenological Knowledge in 19th-Century America." *Centaurus* 55, no. 2 (2013): 104-30. doi:10.1111/1600-0498.12015. 105-106

¹⁰ Ibid; Primary Source seen in Smith-Rosenberg, Carroll, and Charles Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *Women's Bodies*. doi:10.1515/9783110976328.40.

Phrenologists held that generally, “women were known for exquisiteness, emotion, susceptibility, and ‘devotion to offspring,’ as well as their secrecy, artifice, and nervousness.”¹¹

Whereas biological arguments against professional women centered on what at the time were considered scientific givens, moral arguments tended to focus on feminine personality traits and their incompatibility with professionalism. One such argument claimed that women made decisions based on sentiment rather than logic and reason, which were considered prerequisites for medical professionals.

Johann Spurzheim, for example, argued that “women excelled in feeling, men in intellect,” implying that the two were mutually exclusive. This sentiment had its roots in Enlightenment ideas regarding rationality, and was only compounded with the rise of science of difference.¹² Religion, and Christianity in particular, directly shaped many of the moral arguments against female professionalism. The Fall of Eve was often used as an example of women’s weak will and poor decision-making, further justifying their exclusion from professional circles. The same beliefs ordained women’s traditional roles as wife and mother, positing them as divinely sanctioned. Such beliefs saw women doctors and professionals in general as not just unacceptable, but blasphemous.

Social arguments against female physicians rested on the broader communal consequences of women entering the field of medicine. One version of this type of argument held that if women were to stop caring for the home, then men would

¹¹ Bittel, Carla. “Woman, Know Thyself: Producing and Using Phrenological Knowledge in 19th-Century America.” *Centaureus* 55, no. 2 (2013): 104-30. doi:10.1111/1600-0498.12015. 106.

¹² *Ibid*, 107.

have to replace them. The widespread belief in separate sphere ideology—which posited the home as the exclusive reserve of women—made such an idea seem absurd, if not impossible. Women, it was assumed, would not leave home to work in such a demanding environment. This, of course, ignored all of the women who worked outside of the home, as well as the terrible demands of maintaining the late nineteenth-century home. Another argument in a similar vein discussed the ramifications of mothers leaving children behind to go work: This would result not only in the children being neglected, but also in the female physician’s continuous distraction, which would adversely affect patient care. This type of argument assumed that women were the sole caregivers for children, and also that poor and working class women, who had no choice but to earn a living, did not care adequately for their children.

Other social arguments focused on the effects that female students and physicians would have on their male classmates and colleagues. Men were presumed to behave differently in the company of women than when in a homosocial environment, and male physicians were no different. Opponents of women physicians claimed that male physicians’ behavior was less constrained, and thus better suited for the medical profession, in the absence of women.¹³ Male medical students at the time were often seen as boisterous, loud, and rambunctious, often coming from lower middle class families. Opponents of women physicians felt that the presence of ladies might serve to curb the behavior of male students. While it

¹³ Skinner, Carolyn. *Studies in Rhetorics and Feminisms : Women Physicians and Professional Ethos in Nineteenth-Century America*. Carbondale, IL, USA: Southern Illinois University Press, 2014. Accessed April 22, 2016. ProQuest ebrary, 7-41.

was not clear how this aided their education, male medical students closely guarded these traditional homo-social environments nevertheless.

As noted in the previous chapter, these same social arguments also posited that the study of medicine made female students more masculine. Such claims may have been meant to counter the condemnation of male students in Philadelphia who assaulted and harassed a small group of female students at a hospital lecture. While advocates for the female students claimed that the man did not act in a gentlemanly manner, the reciprocal accusation was often leveled at the women. The anonymous author of the pamphlet *Men and Women Medical Students, and the Woman Movement* stated plainly “There is probably no profession, in the preparation for, or the practice of which a greater tendency exists to make ‘*manly women*,’ than in that of medicine, unless we except *the military*.”¹⁴ He goes on to say that women students who have their own colleges, their own instructors, when asking to enter a male learning environment, that “they not only want their own rights, but they want our rights also.”¹⁵ The author of this pamphlet emphasized that the problem with women studying medicine was in the impropriety of them studying intimate physical problems in the presence of male students and instructors. The author did concede that women may study medicine if they so choose, but they would do so in the face of a “very large and sensible portion of the people of this country, both men and women, [who] agree in the opinion that it is unwise and inappropriate for women to become medical practitioners.”¹⁶ The author drew the line, however, at

¹⁴ *Men and Women Medical Students, and the Woman Movement*. Philadelphia, 1870. 6.

¹⁵ *Ibid*, 9.

¹⁶ *Ibid*, 9.

women studying medicine *with men*. This objection made clear that for many the biggest problem with women studying medicine was the violation of societal propriety that would occur if they were to study in the presence of men.

Some women made similar arguments, particularly when discussing the intrusion of men into childbirth. Nevertheless, those who held that there was no place in medicine for women quickly countered such arguments. John Maubrey argued:

MEN...being better versed in *Anatomy*, better acquainted with Physical helps, and commonly endued with greater *Presence of Mind*, have been always found readier or discreeter, to devise something more new, and to give quicker *Relief* in Cases of *difficult* or *preternatural* BIRTHS, than common MIDWIVES generally understand.¹⁷

Maubrey believed that the skill of male-midwives was superior to that of female midwives. His points about men being more innovative and having greater presence of mind relied on fixed ideas of masculinity and femininity, views that were broadly accepted socially, and increasingly given the imprimatur of empirical research, such as phrenology. Because men were seen as more self-possessed and women were subject to nervous complaints and delicacy, it was clear that even in what seemed clearly to be a women's issue, men could claim to be superior problem-solvers and caregivers. Maubrey and others believed that because problems in childbirth occurred so frequently, more women and families would seek to have a man-midwife or a physician present at the birth of their children.

¹⁷ Primary source, as seen in Donegan, Jane. "'Safe Delivered,' but by Whom? Midwives and Men-Midwives in Early America." In *Women and Health in America*, edited by Judith Walzer Leavitt, 302-18. Madison: University of Wisconsin Press, 1984.

So, how did female physicians counter these opposing arguments? Initially, they used interestingly similar claims to support their positions. Medical care was linked to the task of caregiving, which had traditionally been, many argued, the exclusive province of wives and mothers. It was only in the middle of the nineteenth century when medicine became more formalized and professional that men began to take over even those areas of medicine that had before been the exclusive domain of women—the emergence of male midwives provides the perfect example of this. One of the strongest arguments in support of women physicians suggested that they were not only plausible, but also absolutely necessary in order to provide medical care to women while respecting their modesty and observing social norms. This argument provided an important counterweight against the violation of propriety that would result from women seeing male patients' bodies in the course of treatment.¹⁸

Many of the advocates for female physicians emphasized the argument that women doctors should and could care for other women. This was especially true in their discussion of child-birth. While a significant proportion of children were delivered by midwives, the emergence of forceps and other technological and methodological advances caused physicians and surgeons to be increasingly involved in the process. At first, they were involved only with difficult or troublesome births, later extending their reach to prolonged deliveries, and eventually claiming that expert knowledge was needed for every childbirth. The American Medical Association established a Section on Practical Medicine and

¹⁸ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 152.

Obstetrics in 1859, later renamed the Section on Obstetrics and Gynecology.¹⁹

Before obstetrics emerged as a valid specialty, it fell under the purview of every physician and general practitioner. Opposition to male-directed deliveries was hardly a novel phenomenon—Samuel William Fores published his work *Man-midwifery dissected; or the family obstetric-instructor* in 1763, and detailed in it that “Man-midwifery [was] a personal, a domestic, and a National evil.”²⁰

Women physicians’ opposition to male-midwifery was similar in that it felt that men supervising the process of childbirth was a violation of societal values, and incredibly embarrassing for the pregnant woman. However, their criticisms did not stop with male midwives or physicians. They also critiqued midwives, arguing that most midwives lacked the proper education to preside over childbirth. Their presence could satisfy the need for modesty, but would potentially result in generally worse outcomes due to lack of knowledge about the best procedures, when to use forceps and when to wait, and ignorance about potential complications. The best solution to the problem was therefore, they argued, to have a woman with a proper medical education, supervise the delivery process, and educate other women about their bodies. This argument demonstrates the way that women often chose to work *within* the system, rather than fighting to change societal norms. They relied on and even reinforced the same ideas of gender and modesty that were used to bar them from medical practice.

¹⁹ Borst, Charlotte G. "The Professionalization of Obstetrics." In *Women, Health, and Medicine in America*, edited by Rima D. Apple, 203. New York: Garland Publishing, 1990.

²⁰ S.W. Fores. *Man-Midwifery Dissected; Or, the Obstetric Family-instructor. For the Use of Married Couples, and Single Adults of Both Sexes ... In Fourteen Letters Addressed to Alex. Hamilton ... Occasioned by Certain Doctrines Contained in His Letters to Dr. W. Osborn*. London, 1793. 173

Sophia Jex-Blake, one of the earliest female English physicians and amongst the first group of female undergraduates to study at a British university, traced this historical trajectory of midwifery. She argued that women held positions in medical-related fields as midwives for centuries before men began to question their authority. She cited Margaret Cobbe as the first midwife, highlighting Cobbe's yearly salary from the Crown starting in 1469.²¹ Jex-Blake attributed the entrance of men into British childbirth to the poor education of their female midwives. She supported this assumption by pointing to continental Europe, where, "owing to their better education, the midwives retain much of the position that they have for a time lost in England."²² American midwives, likewise, had lost their social position, due to their insufficient education.²³ She also pointed to the example of Russia, where "a medical man is very rarely called in; notwithstanding, fatal cases are of far less frequent occurrence in Russia than in England."²⁴ Jex-Blake suggested that with properly trained female physicians and midwives, male oversight of birth was unnecessary, and that treatment by a competent female midwife would often result in more positive outcomes.²⁵

Historian Frances E. Kobrin further illuminated the plight of the American midwife. While Jex-Blake spent time training in the United States, she was writing to a primarily English audience, and so addressed primarily English situations. Kobrin examines the American midwife, who was also, she argues, plagued by poor

²¹ Jex-Blake, Sophia. *Medical Women: A Thesis and a History*. New York: Source Book Press, 1970. 16.

²² Ibid. 26.

²³ Ibid, 27.

²⁴ Ibid

²⁵ Ibid

education, socioeconomic obstacles, and incredibly high rates of infant mortality and preventable maternal deaths due to puerperal sepsis, as well as high rates of neonatal ophthalmia.²⁶ Kobrin argues that while almost fifty percent of births were attended by a midwife, many were also supervised by general practitioners. Importantly and contrary to arguments being made by male physicians, the results obtained by general practitioners were not significantly better than those obtained by female midwives. When female midwives were chosen, they often “shared race, nationality, and language with their customers”, an important factor considering one-third of the nation’s population was composed of African Americans and recent immigrants.²⁷ Historian Nancy Theriot argues that those women and families that turned to male physicians for childbirth “hoped to have safer and less painful birth experiences...[but] the childbirth experience was actually full of new dangers and new sources of pain and anxiety.”²⁸ The new source of anxiety was, Theriot, often linked to the embarrassment of being seen by a man in the intimate situation of giving birth.

Countering the argument that women were unsuited to medical work by virtue of their innate delicacy, Jex-Blake cited the universal approval that met Florence Nightingale’s work. Nightingale was a nurse, and was well known for her work during the Crimean War. She and Elizabeth Blackwell shared a long and

²⁶ Leavitt, by Frances E. Kobrin, “The American Midwife Controversy: A Crisis of Professionalization.” In *Women and Health in America: Historical Readings*, edited by Judith Walzer and Ronald L. Numbers. Madison, WI: University of Wisconsin Press, 1984. 218. Elizabeth Blackwell also lost much of the vision in her left (?) eye due to neonatal ophthalmia infection after handling a sick infant. Neonatal ophthalmia was defined as the occurrence of conjunctivitis (also known as pinkeye) within the first month of life.

²⁷ Ibid, 217.

²⁸ Theriot, Nancy M. *Mothers and Daughters in Nineteenth-century America: The Biosocial Construction of Femininity*. Lexington, KY: University Press of Kentucky, 1996. 52.

complex relationship, beginning with their shared interest in the role of women in medicine as well as their advocacy for increased hygiene and sanitation in healthcare. Their relationship eventually grew distant as they argued over the proposed location of a proposed women's hospital, and Blackwell later refused to serve as superintendent of Nightingale's school of nursing. Nightingale described their differences as Blackwell attempting to "educate a few highly cultivated [women]—[and herself] to diffuse as much knowledge as possible."²⁹ Nightingale was very well regarded by English society, which Jex-Blake used to further her argument for women physicians in her work *Medical Women: A History and a Thesis*:

While almost everybody applauds and respects Miss Nightingale and her followers for their brave disregard of conventionalities on behalf of suffering humanity, and while hardly any one would pretend that there was any want of feminine delicacy in their going among the foulest sights and most painful scenes to succour, not their own sex, but the other, many people yet profess to be shocked when other women desire to fit themselves to take the medical care of their sisters who would gladly welcome their aid.³⁰

Jex-Blake used this type of rhetoric throughout her book to justify female physicians. The public admired Florence Nightingale's nursing work, and as Jex-Blake made clear, contrary to popular opinion, Nightingale and her followers often exposed themselves to decidedly un-delicate sights and sounds to attend to wounded men. Despite the fact that Nightingale's care for wounded men flew in the face of Victorian ideals surrounding modesty and the exposure of bodies, England celebrated her work. Therefore, Jex-Blake argued, the reaction that women physicians received was disproportionately negative. She argued, in fact, that

²⁹ Boyd, Julia. "The Art of Medicine: Florence Nightingale and Elizabeth Blackwell." *The Lancet*. May 2, 2009. Accessed March 7, 2016. doi:[http://dx.doi.org/10.1016/S0140-6736\(09\)60845-X](http://dx.doi.org/10.1016/S0140-6736(09)60845-X). 1516

³⁰ Jex-Blake, Sophia. *Medical Women: A Thesis and a History*. New York: Source Book Press, 1970. 40,

reception to female doctors should be more positive than Miss Nightingale and her disciples received, given that they did not seek to violate social norms to the same extent.

To counter biological arguments regarding women's physical inability to deal with the stresses of practicing medicine, women used counterexamples such as washerwomen to prove that labor in itself was not detrimental to female health.³¹ They instead attributed the physical and mental ailments that were so rampant amongst American women to societal factors such as overly restrictive clothing and a sedentary lifestyle. Dr. Alice Stockham drew the distinction clearly, stating that "girls and women can bear study, but they cannot bear compressed viscera, tortured stomachs, and displaced uterus," symptoms that were directly attributable to fashionable clothing.³² Stockham's argument drew directly on her authority as a physician to criticize societal norms, and doing so, exonerated women from the idea that they are physically incapable of significant mental and intellectual exertion, while demonstrating their capacity to make scientific arguments.

Women used the very same scientific reasoning of which they were allegedly incapable to refute the biologically based arguments of their opponents. At this time, the field of statistics had emerged and was increasingly used in scientific publications, and so women physicians turned to the same tool. Similarly inclined women scientists conducted surveys sent out to large groups of women physicians, polling them on their physical health prior to practicing medicine as compared to

³¹ Smith-Rosenberg, Carroll, and Charles Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *Women's Bodies*. doi:10.1515/9783110976328.40. 342.

³² Ibid 343.

their health after five years of practice. A similar survey was sent out inquiring into women's self-reported satisfaction at their performance as mothers and wives, with a sizable majority reporting that they felt their profession had a positive effect on their domestic lives.³³ These types of rebuttals were particularly clever, as they forced acceptance of women as rational, scientific minds, and also demonstrated the fallacy of the assumptions that professional employment would negatively influence their physical health or domestic roles.

Similarly, some advocates of female medical practitioners embraced phrenology to make their case. At the heart of their arguments lay the fact that men and women had all the same organs, though they differed in size and development. This meant that women had the potential to be doctors (and professionals in general), and through intentional development, could acquire the same reasoning and scientific skills that male physicians had.³⁴ Professional training, they argued, did not necessarily mean renouncing feminine values such as compassion. In fact, the combination of masculine-gendered scientific knowledge with the innately feminine compassion was posed as something that only women physicians could offer the medical community.

Elizabeth Blackwell and Lydia Folger Fowler, the first and second female M.D.s in the United States, both practiced phrenology. Historian Carla Bittel describes Fowler as using "phrenology to create scientific roles for women, making

³³ Skinner Forty-four of fifty-two surveyed felt their profession benefitted their domestic lives.

³⁴ Bittel, Carla. "Woman, Know Thyself: Producing and Using Phrenological Knowledge in 19th-Century America." *Centaurus* 55, no. 2 (2013): 108. doi:10.1111/1600-0498.12015.

them keepers of scientific knowledge, inside and outside of the home.”³⁵ In actively partaking in phrenology, women were able to manipulate its conclusions and interpretations. Doing so also demonstrated their ability to think rationally. Many well-known feminists such as Lucretia Mott and Elizabeth Cady Stanton, as well as female physicians including Elizabeth Blackwell, Harriot Hunt, and Lydia Folger Fowler were followers of phrenology, all of whom argued that the subtle but distinct female traits phrenology explained were helpful and useful to society, and that women deserved equal rights on the basis of their essential equality.³⁶

Lines of argument centering around female students’ civilizing effect were made very clear in the editorial responses to the Jeering Incident mentioned in the previous chapter, in which a group of students from the Women’s Medical College of Philadelphia were harassed by a group of men when they attended a hospital lecture. Opinions that supported the female students often did so by claiming that women had a civilizing and humanizing influence on male medical students, known throughout Philadelphia society at least for their crudeness and raucous behavior.³⁷ Supporters of female medical student denigrated the un-gentlemanly conduct of the male harassers while extoling the ladylike propriety of the female students and physicians.

Some advocates for female physicians argued not against any of the individual consequences—the perversion of feminine purity or modesty—but

³⁵ Ibid, 112.

³⁶ Ibid.

³⁷ Skinner, Carolyn. *Studies in Rhetorics and Feminisms : Women Physicians and Professional Ethos in Nineteenth-Century America*. Carbondale, IL, USA: Southern Illinois University Press, 2014. Accessed April 22, 2016. ProQuest ebrary, 26

against the very premises upon which the oppositional arguments were based. The consequences many feared, were unlikely, they argued, because medicine itself was a noble pursuit, one too pure to be sexualized or socially problematic. In fact, because the pursuit of knowledge was cerebral, to be pursued, they argued, by the genderless mind, to suggest such concerns perverted an otherwise higher calling.³⁸ Those medical students or physicians that claimed that there was something unclean or sexual about medicine fundamentally misunderstood the nature of their work. An editorial claimed:

If all medical students could be endowed with a proper conception of the work they have in hand they would quickly part with all restricting observances, would be transported to that ideal sphere where mind holds communion with the Infinite... and where no unclean thought is allowed to enter.³⁹

As well as negative arguments countering opponents' points, women physicians also offered positive arguments on their professional necessity. A large part of these positive arguments centered on countering the negative effects of modesty on women's health, due purely to the reluctance of women to speak to male doctors about embarrassing or delicate medical complaints. Jex-Blake addressed this topic in her thesis:

Of the Boston Hospital for Women and Children I can speak from lengthened experience in it as a student. When standing in its dispensary I have over and over again heard rough women of a very poor class say, when questioned why they had not had earlier treatment for certain diseases, "Oh, I could not go to a man with such a trouble, and I did not know till just now that ladies did this work;" and from others have repeatedly heard different expressions

³⁸ Ibid, 27.

³⁹ Editorial, *Press*, seen in Skinner, Carolyn. *Studies in Rhetorics and Feminisms : Women Physicians and Professional Ethos in Nineteenth-Century America*. Carbondale, IL, USA: Southern Illinois University Press, 2014. Accessed April 22, 2016. ProQuest ebrary. 27.

of the feeling that, “It’s so nice, isn’t it, to be able at last to ask ladies about such things?”⁴⁰

This introduces an element of class to the discussion—Jex-Blake argues that not only do women help other women, but that educated, financially secure women help *less fortunate* women, “women of a very poor class.”

This was a strong argument because it highlighted the charitable nature of medicine, which women were traditionally known and celebrated for both inside and outside the profession. Jex-Blake also noted “cases connected with stories of shame or sorrow to which a woman’s hand could far most fittingly minister, and where sisterly help and counsel could give far more appropriate succor than could be expected from the average young medical man.”⁴¹ This again appealed to the desire (and expectation) of women to help their less fortunate sisters. Using the word “minister” brought to mind religion, as did the word sisterly which evoked images of a sisterhood similar to that amongst nuns. Referring to religious values of charity was an effective counter to the argument that women were not suitable to medicine due to their divinely ordained social roles as wives and mothers.

Finally, women physicians were able to negate arguments that they were unable to think scientifically, by doing scientific research that they presented to a much broader audience. Mary Putnam Jacobi was perhaps the most well respected of the first generation of women physicians, and this was, in part, due to her use of rational reasoning and scientific method. Her publications contributed not only to

⁴⁰ Jex-Blake, Sophia. *Medical Women, a Thesis and a History. I. Medicine as a Profession for Women. II. The Medical Education of Women. I. The Battle in Edinburgh. II. The Victory Won.* By Sophia Jex-Blake. Edinburgh: Oliphant, Anderson, & Ferrier, 1886. 43-44

⁴¹ Ibid, 44.

the scientific and medical communities, but were written for popular audiences.⁴²

Alice Hamilton, some time later, managed to make so sizable a contribution to the field of toxicology that she became the first female faculty member of Harvard Medical College. It was clear that Harvard preferred not to hire her, but did so because her expertise far outstripped the perceived disadvantage of her gender.⁴³

Many of the scientific arguments women made in their defense relied on demonstrating their expertise and authority. Why was authority important? 'Scientific' arguments against female physicians published by male physicians and scientists were given credence by society due to the perceived expertise of the authors. By using the same professional rhetoric and reasoning, women physicians were able to counter these arguments. More importantly, their treatises and articles allowed them to use the science of medicine to influence social perceptions of women in general, shaping and influencing the medical, sexual, and social education of women throughout the nation. Because women physicians typically experienced difficulty in converting their male colleagues' opinions, they instead turned to the middle class as a whole.⁴⁴ Their efforts slowly worked to alter perceptions of professional women, and reshaping, if not rejecting, presumed gender norms. This strategy reflected their desire to be accepted by society as a whole, which would provide them with social and economic stability. Of course, they still pursued the

⁴² Morantz-Sanchez, Regina Markell. "Separate but Equal: Medical Education for Women." In *Sympathy and Science: Women Physicians in American Medicine*, 73. New York City, NY: Oxford University Press, 1985. 190.

⁴³ Morantz-Sanchez, Regina Markell. "Separate but Equal: Medical Education for Women." In *Sympathy and Science: Women Physicians in American Medicine*, 73. New York City, NY: Oxford University Press, 1985. 313-14.

⁴⁴ Skinner, Carolyn. *Studies in Rhetorics and Feminisms : Women Physicians and Professional Ethos in Nineteenth-Century America*. Carbondale, IL, USA: Southern Illinois University Press, 2014. Accessed April 22, 2016. ProQuest ebrary, 33.

acceptance of male physicians, which would result in more professional opportunities and perceived professional gender equality.

The written work of women physicians, and their representations made by themselves and others, allows us to view how the doctors and scientists felt they should be portrayed. Often, the first example of medical writing a physician published was a medical school thesis. Theses often reflected the interests of the physicians, both in terms of the populations of interest and the favored medical ideology. For example, Elizabeth Blackwell wrote on the treatment of typhus, a disease which disproportionately affected the poor, going on to spend most of her career treating poor women and children.⁴⁵ Women physicians were encouraged to write theses more often than their male counterparts. Furthermore, they were more frequently edited. Edits, frequently made by male professors, often did not serve to substantially alter the meaning of the work, suggesting that even the men who were open to the idea of women doctors, who actively worked to make this idea a reality, continued to manifest subconscious judgments on their writing abilities, while equivalent judgments were not made about male students.⁴⁶ Susan Wells examined the theses of students from the Women's Medical College of Philadelphia were compared to those of Jefferson Medical College, both located in Philadelphia, and they were compared to see how much they were edited. This suggests that they were being more closely scrutinized than their male peers.⁴⁷ Following the

⁴⁵ Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Source Book Press, 1970. 81.

⁴⁶ Wells, Susan. *Out of the Dead House: Nineteenth-Century Women Physicians and the Writing of Medicine*. Madison: University of Wisconsin Press, 2001. 82.

⁴⁷ Ibid.

curricular shift of the Women's Medical College of Philadelphia, Hannah Longshore, sister-in-law of the disgraced Joseph Longshore, disguised the hydropathic content of her thesis through strategic editing of its title.⁴⁸

Women physicians put a great deal of thought into how they presented themselves to the profession as a whole. They had a number of different ways of taking ownership of their work – sometimes women signed off their scientific work using their initials, the first initial and last name, the professional prefix of Dr. or suffix of M.D. Sometimes they even signed off as Mrs. Examining the different forms of self-presentation allows us to see where different authors derived their authority. For example, an author who signed off as Mrs. advising women on the correct ways to swaddle their babies derived her authority not as a professional, but as a married woman, and presumably, as an experienced mother. Utilizing Dr. or M.D. reflected a desire to use one's professional identity as a source of authority and legitimacy. Use of initials, on the other hand, aimed for authority by virtue of disguising one's sex.

Use of initials was not only limited to how the women physicians signed their work, but also how they appeared on documents written by others—Elizabeth Blackwell was designated E. Blackwell on an official roster of 1848 graduates of Geneva Medical College, between Payton Dunwoodie Beecher and John Brant.⁴⁹ This demonstrates the way the male-dominated medical school, which refused subsequent female applicants, attempted to erase Blackwell's femininity and presence.

⁴⁸ Ibid, 104.

⁴⁹ Geneva Medical College 1848 Circular, Accessed at SUNY Upstate Medical University

Women physicians were able to use the same methods used by their opponents to prove they were needed. Where their opponents used phrenology to prove them physically and mentally incapable of the strenuous intellectual labor of medicine, women physicians used phrenology to prove they had the same capacities as men, and could work to develop them if needed. Where men used scientific reasoning to exclude them, women circumvented those arguments in the same way. By simultaneously reifying and subverting gendered expectations of behavior, women physicians were able to make the case that they were not only capable, but a necessary part of the medical profession.

Chapter 3: Women Physicians' Prescriptions and Experiences of Femininity

This chapter serves to discuss the motivations and aims women had for entering the profession of medicine, and then to analyze the impact and changes they sought to make in medicine and in society as a whole as physicians. Generally speaking, women physicians sought to change the ways in which women raised and educated their children. There were a number of social reform causes taken up by women physicians, including dress reform, temperance, and educational reform. Blackwell herself wrote extensively on the education of girls. She aimed to teach mothers how to educate their daughters about sex.

The emergence of women physicians in the nineteenth century occurred within a wider context of societal changes, one of which was a move towards mass industrialization. Whereas previously, the majority of labor was unwaged (often agricultural or domestic labor), increasing industrialization and urbanization resulted in the increase of wage labor. Jeanne Boydston argued in her book *Home and Work* that the rise of waged labor led to the diminution of the value of unpaid labor.¹ This disproportionally affected women's labor. While some women worked in factories and earned wages, they were also responsible for domestic labor and childrearing. The unpaid nature of these tasks, despite their rigorous nature, led to their being less valued by society. This in turn fostered the idea that women who were performing exclusively domestic and childrearing labor were in fact not useful. This cultivated in women a strong desire to be of use. Many women acceded to this

¹ Boydston, Jeanne. "Home & Work: Housework, Wages, and the Ideology of Labor in the Early Republic." *Journal of Interdisciplinary History* 22, no. 4 (1992): 750. doi:10.2307/205258. 30

desire by pursuing work outside the home, whether that was in factories, waged labor settings, or in a professional setting such as medicine.²

Many women physicians cited this desire to be useful as a motivating factor for choosing medicine. Elizabeth Blackwell, when discussing the process of choosing a profession, wrote of her desire to find a useful one.³ Alice Hamilton wrote, when weighing medicine against other professions, of being able to be of use anywhere, adding the factor of mobility to her consideration.⁴

Cathy Luchetti discusses the motivations many women physicians had for entering the field in *Medicine Women: The Story of Early-American Women Doctors*. Beyond the desire to serve the community, many women were driven by the desire to learn. Others had a nursing background and felt it was the natural progression to go into medicine. There was also often a role model, either an older woman doctor, or a male medical influence. Many women doctors had fathers or brothers who were also in medicine, and served as their primary inspiration. Interestingly, some women ended up pursuing medicine in order to aid their physician husbands. This seems at odds considering that medicine had been portrayed as a competing force with marriage, rather than a cooperative one. However, in the sparsely populated West, hospitals were rare, and so male physicians usually needed partners to help

² Ibid, 162.

³ Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Source Book Press, 1970. 26

⁴ Hamilton, Alice. *Exploring the Dangerous Trades; the Autobiography of Alice Hamilton, M.D.* Boston: Little, Brown and Company, 1943.

with their practice.⁵ In this case, the pursuit of medicine was the fulfillment of both a professional calling and a domestic duty to help the family as much as possible.

We have seen that women physicians had to renegotiate notions of femininity in order to reconcile their womanhood and their professionalism. While the pursuit of medicine constituted in some ways a radical departure from gendered expectations of behavior, most women physicians continued to conform to these expectations to some extent. Many were married and often had children. According to Cathy Lucetti, almost one-third of female physicians were married before 1900.⁶ For many, in many rural areas of the American West, where hospitals were sparse, it was fairly commonplace for wives to go into practice with their husbands. Still, there were some that departed from such expectations, like Mary Edwards Walker. Walker wore trousers and bloomers, divorced her husband upon discovering he was having an affair, and was the only woman physician to work on the battlefield in the Civil War. She treated wounded Union soldiers despite not receiving compensation, as her presence was not officially sanctioned. Nevertheless, her aid was welcomed by the surgeon she worked alongside, so much so that he offered to split his own salary with her. She refused his offer, and for her work in the Civil War, became the only woman to be awarded the Congressional Medal of Honor.⁷

⁵ Luchetti, Cathy. *Medicine Women: The Story of Early-American Women Doctors*. New York: Crown Publishers, 1998. 35-45

⁶ Luchetti, Cathy. *Medicine Women: The Story of Early-American Women Doctors*. New York: Crown Publishers, 1998. 83

⁷ "Changing the Face of Medicine | Dr. Mary Edwards Walker." U.S National Library of Medicine. Accessed April 22, 2016.
https://www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_325.html.
Her Medal of Honor was then taken away briefly, and eventually regained posthumously, after her great-niece fought to have it returned.

It is important to note, however, that someone like Walker would have been denied admission to the Elizabeth Blackwell-run medical college associated with the New York Infirmary for Women and Children for being too radical. Blackwell's draw to medicine was not a scientific one, but a moral one. Furthermore, she was a strong proponent of maternalist medicine, which is predicated on the premise that women were morally superior to men. This placed her in opposition to women like Mary Putnam Jacobi, whose guiding principles centered around rational thought, empirical evidence, and contributing to the field of medicine not only through treatment, but also through scientific innovation. The principles that Jacobi embodied made her one of the most well respected women physicians amongst her male colleagues. Regina Markell Morantz-Sanchez poses Blackwell and Jacobi as polar opposites. Not only did they differ in temperament, initial attraction to the field, and approaches to the practice of medicine, they also disagreed on the broader role of the woman physician. Blackwell endorsed the practice of social medicine, and saw medicine as a means of charitable work and reform, whereas Jacobi endorsed the practice of scientific medicine, with all claims backed up by scientific proof before being acted upon. Furthermore, Jacobi thought that the overemphasis on women's moral responsibility and sentiment could hurt their cause, especially when it interfered with their scientific contributions.

While at first glance both moral medicine and scientific medicine do not seem to be mutually exclusive, a closer examination reveals the difficulties involved in reconciling belief in both. For example, in studying the prevention of disease, Jacobi strongly supported the study of bacteriology, while Blackwell focused instead

on sanitation. Blackwell's reasoning for this was not premised on the science of disease, or the presence of microscopic disease-causing organisms, but was instead focused on morality. She believed that health was the norm and disease was the abnormal result of immoral behavior, uncleanness being an example of such behavior. She felt disease could be cured or prevented by living a certain way. This idea of health and lifestyle centered on hygiene. Bacteriology undermined this ideology, by reducing the impact of hygiene on disease prevention, which in turn undermined the conception of the moral basis of disease. Blackwell opposed bacteriology because its implications opposed the moral nature of healthcare, which then subverted her ideas regarding the moral duty of women in medicine. If bacteriology were broadly accepted, then disease would not have a moral basis at all. Consequently, there would be no obligation to instruct the general public on moral issues, such as education and childrearing. This destabilized the grounds upon which Blackwell argues for increased female participation in medicine—their superior moral sensibilities and increased ability to advise the public on moral issues. So belief in bacteriology fundamentally subverted the means for Blackwell's end goal of social reform.

Instead, Blackwell strongly advocated for sanitation, and her Infirmary was one of the first to have an M.D. serving as chair of hygiene. Appointing someone as chair of hygiene was a way of maintaining a constant check on the inherent dirtiness of disease. Bacteriology emerged slightly after Blackwell earned her degree, and seemed to indicate that hygiene, while an important factor, was not in fact sufficient in and of itself to prevent disease. More importantly, bacteriology was also

representative of the triumph of laboratory science over moral truth. Blackwell believed that women had superior moral judgment to men, and believed in their maternal power. In an address delivered at the opening of the London School of Medicine for Women, Blackwell said “whatever revolts our moral sense as earnest women is not in accordance with steady progress.” She believed that the morality of scientific progress should be considered over the perceived scientific benefits of that progress. For example, Blackwell was also opposed to vivisection, because while it had positive intentions, centered in learning, these ends were obtained by morally impermissible means, which would counter correct feminine moral intuition. Jacobi, on the other hand, felt that experimentation and scientific evidence were sufficient to alter beliefs regarding disease, even if they contradicted previous moral theories.

Jacobi’s embrace of masculine-gendered rational thought and scientific reasoning, such as bacteriology, did not preclude her from claiming femininity. One of the ways Jacobi and other women physicians practiced femininity was by engaging with feminine expectations of marriage and motherhood. Mary Putnam Jacobi married Abraham Jacobi, a prominent physician renowned as the father of pediatrics, who also served as president of the American Medical Association.⁸ While Elizabeth Blackwell demonstrated a longstanding wariness of romantic relationships, and consciously chose to avoid engaging in them, referring to her career as putting a barrier between herself and marriage, Jacobi wrote of being

⁸ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 180.

perfectly willing to marry someone, given that they would allow her to pursue her career in the way that she wanted.

Jacobi and Blackwell also had different approaches to advocating for women physicians. Blackwell posited that women had unique talents that made them more suited than men to medicine. Her ideas of maternalist medicine set women apart, and ideally had them serving as compassionate moral police regulating medical authority. Blackwell's arguments relied on the inherent differences between male and female characteristics, using a sort of female exceptionalism in order to convey the absolute need for women in medicine. Jacobi, on the other hand, was of the belief that men and women were equal and similar in capacity, and ought to prove those capabilities through scientific achievement. She distanced herself from medical institutions run exclusively by women, refusing a teaching position at the Women's Medical College of Philadelphia.⁹ While Jacobi didn't entirely discredit the advantage of feminine characteristics in physicians, she felt these differences were acquired rather than inherent.¹⁰ Regardless of this, she felt, women should be completely integrated into medicine in order to obtain equality.

Dr. Sarah Dolley, an early professor of obstetrics at the Women's Medical College of Philadelphia, discussed her vision of women as medicine's moral compasses in [year] closing lecture at the WMCP:

Are women to be a power for good in the medical profession?...With glad thankfulness we can say the most cultivated communities no longer regard the entrance of woman into the profession as an impertinence. But are our

⁹ Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 184.

¹⁰ Ibid 187.

responsibilities lessened by this one step in advance?...No!...If you need not show cause why you have gone in the face of old-time prejudices, and essay to enter a profession which is justly given high place, and held in reverence by the people, you must show a seriousness of moral purpose, and must bring into the Medical Profession that which it has a right to expect from you, a moral power which, like the “little leaven hid in three measures of meal,” shall “leaven the whole lump,” and so do your part...to maintain the integrity, to preserve the facts, and profit by the traditions of Medicine.¹¹

This was very much in line with Blackwell’s idea of thought—that the presence of women in the profession, even if they were not the majority, would work to morally elevate and purify the profession as a whole.

Blackwell herself came from a family of active social reformers. Her father was an abolitionist, and her sister-in-law was women’s rights activist Lucy Stone. This spirit of activism was a strong motivation when Blackwell was deciding on a profession. Simply stated, Blackwell was interested first in social causes such as abolition, education reform, and dress reform, and then in medicine, which she saw not as an end in and of itself, but as a means to continue to aid society in a meaningful way. Having the authority of a well-educated physician allowed her a platform from which she could write and be taken seriously. She wrote pamphlets on how young girls should be educated, on the importance of maintaining a hygienic environment as relating to disease prevention, and other social causes. Her credibility was solidified by her professional qualifications.¹²

¹¹ Dolley, Concluding Lecture to WMCP graduating class, 1874. sent upon request to. accessed Aug. 13, 2015, at the National Library of Medicine, at the National Institutes of Health, Bethesda, MD.

¹² Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985. 190.

Furthermore, Blackwell used her profession as a way to cut herself off from forming romantic attachments. She explained herself in her autobiography that she was not in fact repulsed by men. Rather, she felt herself too susceptible to romantic feelings, despite an aversion to lifelong intimacy. In the pursuit of her great and noble work, she was able to present herself with an ironclad reason not to engage too strongly with men in a romantic fashion. Despite this desire to avoid marriage, Blackwell was able to use what she considered her natural maternal instincts to take care of patients.

Blackwell also eventually adopted a young girl, an Irish immigrant named Kitty. In this way, Blackwell was able to meet the social expectations for women in terms of childrearing and motherhood. Kitty also added value to Blackwell's life, as Blackwell herself told it. Blackwell had been struggling to establish herself professionally in New York, and had been feeling pessimistic and low about her hopes for success. She described the way in which Kitty influenced her as follows: "I desperately needed the change of thought she compelled me to give her. It was a dark time and she did me good—her genial, loyal, Irish temperament suited me."¹³ Her choice to raise an orphaned immigrant, particularly an Irish one, is yet a further extension of her reformist tendencies. At this time, as immigration into the United States increased, various European groups, particularly the Irish and the Germans, were deeply racialized. By plucking a deeply disadvantaged child with no family or resources from the rough and raising her as the daughter of a white middle-class

¹³ Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Longmans, Green, and, 1895, 188.

female physician, Blackwell was performing an act of charity. In so doing, she also managed to reap moral benefits herself, in the form of uplifted spirits.

Still, in her relationship with Kitty we see the blurred nature of Blackwell's ideas concerning medicine and motherhood. Instead of calling Blackwell "mother," Kitty called her "Doctor." In fact, as Blackwell told the story, Kitty was quite taken aback when she came across Blackwell consulting with a male colleague who she called doctor. "After he was gone, she came to me with a very puzzled face, exclaiming 'Doctor, how very odd it is to hear a *man* called Doctor!'"¹⁴ That Blackwell would choose to be called Doctor by her adopted daughter makes a powerful statement about how she saw herself, situating her role as a physician as the forefront of her identity, and melding this role with that of a mother. This reflects back on Blackwell's conception of the role of female physicians. Furthermore, the moral policing role she sought for herself and her colleagues was comparable to the moral supervision a mother would give her child.

In stern contrast to Blackwell's initial revulsion, Marie Zakrzewska demonstrated a very early interest in medicine and science. It is important to note that Blackwell's reaction was likely due to social constructions of the body as vulgar, and her age at the time she first considered medicine meant that she had been more heavily influenced by those social conceptions. Zakrzewska, on the other hand, was introduced to medicine as a young child. When she was quite young, she was living at a midwifery school where her mother studied. She had fallen ill, and had had to have her eyes bandaged. She followed one of the doctors blindly on his rounds.

¹⁴ Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Longmans, Green, and, 1895, 189.

Shortly after the bandages were removed, she was told of a young man who had been poisoned and whose body lay in the morgue. She went to investigate, looked at the body at some length, and turned to leave, only to find that the doors were all locked. She was not let out until the next day. Zakrzewska demonstrated in this anecdote a sort of intellectual curiosity, which is marked in its lack of disgust for the body's supposed vulgarity.¹⁵

While Blackwell describes her initial revulsions in vivid detail, Zakrzewska, younger upon exposure to medicine, and less exposed to social norms in an isolated environment, exhibited an openness to and hunger for learning. It is also interesting to note that Zakrzewska was a Polish immigrant, making her success in America even more remarkable.¹⁶ Zakrzewska came from a family with a strong background of health professionals—her mother was a midwife and her grandmother a veterinary surgeon.¹⁷ She herself was already an established midwife before her immigration to the United States.¹⁸ Elizabeth Blackwell became a mentor to her, encouraging her to attend Western Reserve Medical College in Cleveland and providing financial and professional support prior to and after her graduation. Zakrzewska then worked at the Blackwells' New York Infirmary for Women and Children prior to her move to Samuel Gregory's Female Medical College of New England.¹⁹ In this way, Zakrzewska provides us with a narrative that very much runs

¹⁵ Out of the Dead House Chapter 1, anecdote and analysis

¹⁶ While her family had Polish roots, Zakrzewska herself was born in Berlin, and

¹⁷ Changing the Face of Medicine NIH NLM page, Marie Zakrzewska

¹⁸ EB Autbio.

¹⁹ Changing the Face...

counter to that of Blackwell, prompted by scientific curiosity, rather than social agenda.

Blackwell supported Zakrzewska when she was early in her career, before it became clear that their visions for women physicians were different. Blackwell's relationships with many of her protégées and colleagues were similar in this way—she ended up leaving the New York Infirmary in the hands of her sister Emily when they differed too much in their opinions regarding its management. She and Florence Nightingale, renowned and well-respected nurse during the Crimean War, fell out over the location of a hospital they had planned together, and Blackwell's position in that hospital. She differed with Elizabeth Garrett Anderson, with whom she helped found a women's medical college in London, over its management, and her involvement was gradually scaled back. However, Blackwell makes no mention of any of these disagreements in her autobiography. This suggests that she very much valued the portrayal of unity amongst women physicians. There was enough opposition from society as a whole and from male physicians in particular, that differences were to be discussed privately rather than publicly.

What allowed physicians this level of social authority? Many progressive physicians at this time felt it was their duty not only to treat patients, but to address social ills. The concept of the social organism was very popular at this time. By treating the community as a whole as a single organism, advocates of this philosophy were able to justify having different roles for different individuals. This served as tacit and sometimes overt support for societal discrimination and segregation based on race and gender. How did women physicians participate in

this theory? The social organism theory held that people who held different social positions were equally vital for the healthy functioning of society. This fit in very nicely with what Blackwell and other early women physicians advocated: distinct but equal roles for men and women in medicine and in broader society as a whole. Treating social problems as diseases of the social organism also allowed physicians a unique power to advocate for treatments or cures of these social ills.

While Blackwell and others focused their energy on social reform relating to the perception of gender, some non-white female physicians also used their authority to renegotiate race. Race played a massive role in the availability of healthcare in the nineteenth century. Racist ideas were widespread in this era, and often supported by branches of science such as phrenology. The effects of ingrained racist ideology resulted in increased poverty and decreased access to education for Native Americans and African Americans. Historian Edward H. Beardsley argues that “in the early 1900’s [more than forty years following the Civil War and abolition of slavery], the view still had currency among educated southerners that black women (and men) were psychologically and constitutionally unfit for freedom.”²⁰ For black women, race played a larger role in determining their access to healthcare than gender did, in that they had much less access than white women, and similar access to black men. Similarly, white medical professionals found that African Americans were more likely to have diseases such as tuberculosis, gonorrhea, syphilis, diabetes mellitus, and cancer. Rather than attributing this difference in

²⁰ Pripas-Kapit, Sarah. ““We Have Lived on Broken Promises”: Charles A. Eastman, Susan La Flesche Picotte, and the Politics of American Indian Assimilation during the Progressive Era.” *Great Plains Quarterly* 35, no. 1 (2015): 51-78. doi:10.1353/gpq.2015.0009. 51

frequency to lower income, less education, increased stress, and poor diet, white medical professionals attributed them to inherent biological differences between whites and blacks.

While most women physicians used their professional authority to renegotiate gender, non-white female physicians were uniquely able to use the same methodology to reframe certain assumptions about race. For example, Susan La Flesche Picotte, a physician and member of the Omaha tribe, used her authority to discredit popular conceptions about Native Americans. Picotte began her career at the Office of Indian Affairs, which worked to promote the assimilation of Native Americans.²¹ Picotte's education and Christian faith combined with her Omaha heritage, allowed her to serve as an intermediary between the two groups. For example, she often published about her work with the Omaha people in the Connecticut Indian Association's *Indian Bulletin*. This was mainly read by white middle-to-upper class women, and so Picotte was able to use her knowledge of her audience to portray the Omahas as eager to embrace a white lifestyle, in order to elicit more generous donations.²²

Sarah Pripas-Kapit describes Picotte's aim to be imparting Indian values and mentalities.²³ She goes on to compare Picotte to Charles Eastman, a male Native American physician of the Santee Dakota tribe. While both shared similar stances, including starts at the Office of Indian Affairs before later diverging to oppose

²¹ Ibid.

²² Wells, Susan. *Out of the Dead House: Nineteenth-century Women Physicians and the Writing of Medicine*. Madison: University of Wisconsin Press, 2001. 54.

²³ Pripas-Kapit, Sarah. "'We Have Lived on Broken Promises': Charles A. Eastman, Susan La Flesche Picotte, and the Politics of American Indian Assimilation during the Progressive Era." *Great Plains Quarterly* 35, no. 1 (2015): 51-78. doi:10.1353/gpq.2015.0009. 52

assimilation policies. Pripas-Kapit attributes differences in their stances—Picotte was more receptive to state interference in Native Americans' lives than Eastman—to gender differences and different tribal experience.

While women physicians wrote frequently about their prescriptions for the practice of femininity in the profession, they also often addressed their personal experiences as women and how they felt about the profession. Dr. Alice Hamilton, one of the foremost toxicologists of the age, in her work *Exploring the Dangerous Trades*, discussed her choice to pursue medicine:

There seemed only a few careers open to us—teaching, nursing, the practice of medicine...I chose medicine, not because I was scientifically-minded, for I was deeply ignorant of science. I chose it because as a doctor I could go anywhere I pleased—to far off lands or to city slums—and be quite sure that I could be of use anywhere. I should meet all sorts and conditions of men, I should not be tied down to a school or a college as a teacher is, or have to work under a superior, as a nurse must do.²⁴

This excerpt allows us to draw conclusions about Hamilton's values—while she too, prized usefulness as Blackwell did before her, she also valued her own autonomy and freedom of movement. When discussing her schooling at Ann Arbor, she said it “gave me my first taste of emancipation, and I loved it.”²⁵ Placing that statement in the context of a post-Civil War America allows us to see yet another dimension of meaning. Her words clearly show that she felt a new freedom from a sort of social constraint.

The freedom Hamilton relished was not without its costs, however. Early women physicians often faced ostracization from society as a whole. Elizabeth

²⁴ Hamilton, Alice. *Exploring the Dangerous Trades; the Autobiography of Alice Hamilton, M.D.* Boston: Little, Brown and Company, 1943. 38.

²⁵ Hamilton, Alice. *Exploring the Dangerous Trades; the Autobiography of Alice Hamilton, M.D.* Boston: Little, Brown and Company, 1943. 41

Blackwell wrote of the difficulty involved in finding a place to live while she attended medical college. Zakrzewska faced the same problem in trying to rent an office in which to see patients. It was so difficult for her, in fact, that she was unable to find an office space until Blackwell offered her the parlor of her home. The Jeering Incident, when female students were harassed by men at a lecture, was perhaps the most violent form of harassment documented against women physicians, but it was far from the only such instance. While women physicians worked to try to negotiate a space for themselves as both women and professionals, they couldn't always control how they were seen by others. Despite their best efforts, medicine remained a male-majority field. However, utilizing rhetorical skills in combination with scientific knowledge, they were able to assert themselves as equal participants in the medical profession. Using female medical education, they were able to generate strong support networks that made entry into medicine easier for each subsequent woman. Finally, they were able to use their professional authority to inform social definitions of femininity and race, powerfully reframing these narratives.

Works Consulted:

Apple, Rima D. *Women, Health, and Medicine in America: A Historical Handbook*. New York: Garland Pub., 1990.

Baker, Rachel. *The First Woman Doctor; the Story of Elizabeth Blackwell, M.D.* New York: Messner, 1944.

Bittel, Carla. "Woman, Know Thyself: Producing and Using Phrenological Knowledge in 19th-Century America." *Centaurus* 55, no. 2 (2013): 104-30. doi:10.1111/1600-0498.12015.

"Blackguardism." *Philadelphia Evening Bulletin*, November 8, 1869. Accessed October 15, 2014. <http://doctordoctress.org/islandora/object/islandora:1347>.

Blackwell, Elizabeth. *Pioneer Work in Opening the Medical Profession to Women; Autobiographical Sketches*. New York: Longmans, Green, and, 1895

Borst, Charlotte G. "The Professionalization of Obstetrics." In *Women, Health, and Medicine in America*, edited by Rima D. Apple, 203. New York: Garland Publishing, 1990.

Brandt, Allen M. "Emerging Themes in the History of Medicine." *The Milbank Quarterly* 69, no. 2 (1991): 199-214. Accessed March 16, 2015. JSTOR.

Buettinger, Craig. "Women and Antivivisection in Late Nineteenth-Century America." *Journal of Social History* 30, no. 4 (1997): 857-72. Accessed March 17, 2015. JSTOR.

Bynum, W. F. *Science and the Practice of Medicine in the Nineteenth Century*. Cambridge, England: Cambridge University Press, 1994.

Circular and Catalogue of the Faculty and Officers of the Medical Institution of Geneva College, Geneva, New York, September 1834. Oliphant & Skinner, Auburn. (accessed at SUNY Upstate Medical University Archives, August 4, 2015).

Clarke, Edward H. *Sex in Education, or a Fair Chance for Girls*. Boston: Houghton, Mifflin

Fine, Eve. "Women Physicians and Medical Sects in Nineteenth-Century Chicago." In *Women Physicians and the Cultures of Medicine*, 249. Baltimore, MD: Johns Hopkins University Press, 2009.

Fores, S.W. *Man-Midwifery Dissected; Or, the Obstetric Family-instructor. For the Use of Married Couples, and Single Adults of Both Sexes ... In Fourteen Letters Addressed to Alex. Hamilton ... Occasioned by Certain Doctrines Contained in His Letters to Dr. W. Osborn*. London, 1793. 173

Jex-Blake, Sophia. *Medical Women: A Thesis and a History*. New York: Source Book Press, 1970.

16.

Hudson, Robert P., and Ronald L. Numbers. "Abraham Flexner in Perspective." In *Health and Sickness in America*, edited by Judith Walzer Levitt, 148. 2nd ed. Madison: University of Wisconsin Press, 1985.

Kett, Joseph F. *The Formation of the American Medical Profession; the Role of Institutions, 1780-1860*. New Haven: Yale University Press, 1968.

Krug, Kate. "Women Ovulate, Men Spermate: Elizabeth Blackwell as a Feminist Physiologist." *Journal of the History of Sexuality* 7, no. 1 (1996): 51-72. Accessed April 1, 2015. JSTOR.

Leavitt, Judith Walzer. *Women and Health in America: Historical Readings*. Madison, Wis.: University of Wisconsin Press, 1984.

Levine-Clark, Marjorie. *Beyond the Reproductive Body: The Politics of Women's Health and Work in Early Victorian England*. Columbus: Ohio State University Press, 2004.

Long, Lisa A. *Rehabilitating Bodies: Health, History, and the American Civil War*. Philadelphia: University of Pennsylvania Press, 2004.

Longshore, Joseph. "The First Female Medical College: "Will You Accept or Reject Them?"" The First Female Medical College: "Will You Accept or Reject Them?" October 4, 1850. Accessed December 12, 2014. <http://doctordoctress.org/islandora/object/islandora:1496>.

Loudon, I. "Book: Scanty Particulars: The Strange Life and Astonishing Secret of Victorian Adventurer and Pioneer Surgeon James Barry." *BMJ* 324, no. 7349 (2002): 1341. doi:10.1136/bmj.324.7349.1341.

Loudon, Irvine. *Medical Care and the General Practitioner, 1750-1850*. Oxford, England: Clarendon Press, 1986.

Löwy, Ilana. "Historiography of Biomedicine: "Bio," "Medicine," and In Between." *ISIS*, 2011, 116-22. Accessed April 1, 2015. JSTOR.

Luchetti, Cathy. *Medicine Women: The Story of Early-American Women Doctors*. New York: Crown Publishers, 1998.

Lucier, Paul. "The Professional and the Scientist in Nineteenth-Century America." *ISIS* 100, no. 4 (2009): 699-732. Accessed March 17, 2015. JSTOR.

Marshall, Clara. *The Woman's Medical College of Pennsylvania: An Historical Outline*. Philadelphia, Pennsylvania: P. Blakiston, 1897. 20. The (?) was original to the primary source.

Mead, Kate Campbell. "New York and London. - Elizabeth Blackwell, M.D., Geneva, New York, 1849." In *Medical Women of America; a Short History of the Pioneer Medical Women of America and a Few of Their Colleagues in England*, 21-24. New York: Froben Press, 1933.

Morantz-Sanchez, Regina. "Feminist Theory and Historical Practice: Rereading Elizabeth Blackwell." *History and Theory* 31, no. 4 (1992): 51-69. Accessed April 1, 2015. JSTOR.

Morantz-Sanchez, Regina. "Negotiating Power at the Bedside: Nineteenth-Century Patients and Their Gynecologists." *Feminist Studies* 26, no. 2 (2000): 287-309. Accessed April 1, 2015. JSTOR.

Morantz-Sanchez, Regina Markell. *Sympathy and Science: Women Physicians in American Medicine*. New York: Oxford University Press, 1985.

More, Ellen S., Elizabeth Fee, and Manon Perry. *Women Physicians and the Culture of Medicine*, 3. Baltimore, MD.: Johns Hopkins University Press, 2009.

Penny, Virginia. "Physicians." In *The Employments of Women: A Cyclopaedia of Woman's Work*, 15. Boston, MA: Walker, Wise, and Company, 1863.

Pernick, Martin S., and Ronald L. Numbers. "The Calculus of Suffering in 19th-Century Surgery." In *Sickness and Health in America*, edited by Judith Walzer Levitt, 98. Madison: University of Wisconsin Press, 1985.

Piepmeyer, Alison. *Out in Public: Configurations of Women's Bodies in Nineteenth-Century America*. Chapel Hill: University of North Carolina Press, 2004.

"Pioneers in the Face of Adversity: 'The Mob of '69'" January 1, 1869. Accessed December 13, 2014. <http://doctordoctress.org/islandora/object/islandora:1347>

Pripas-Kapit, Sarah. "'We Have Lived on Broken Promises': Charles A. Eastman, Susan La Flesche Picotte, and the Politics of American Indian Assimilation during the Progressive Era." *Great Plains Quarterly* 35, no. 1 (2015): 51-78. doi:10.1353/gpq.2015.0009.

Rosenberg, Charles E., and Ronald L. Numbers. "The Therapeutic Revolution: Medicine, Meaning and Social Change in 19th-Century America." In *Sickness and Health in America*, edited by Judith Walzer Leavitt, 39-50. Madison: University of Wisconsin Press, 1985.

Ross, Ishbel. *Child of Destiny; the Life Story of the First Woman Doctor*. New York: Harper, 1949.

Rothstein, William G., and M.D. Rare Book Collection of Rush University Medical Center at the University of Chicago Friedberg. *American Physicians in the Nineteenth Century: From Sects to Science*. Baltimore: Johns Hopkins University Press, 1972.

Sahli, Nancy. "A Stick to Break Our Heads With: Elizabeth Blackwell and Philadelphia Medicine." *Pennsylvania History* 44, no. 4 (1977): 335-47. Accessed April 1, 2015. JSTOR.

Shryock, Richard Harrison. *Medicine in America: Historical Essays*. Baltimore, MD.: Johns Hopkins Press, 1966.

Sicherman, Barbara, and Alice Hamilton. *Alice Hamilton, a Life in Letters*. Cambridge, Mass.: Harvard University Press, 1984. 36.

Skinner, Carolyn. *Studies in Rhetorics and Feminisms : Women Physicians and Professional Ethos in Nineteenth-Century America*. Carbondale, IL, USA: Southern Illinois University Press, 2014. Accessed September 12, 2015. 24. ProQuest ebrary. Women Physicians and Professional Ethos.

Smith-Rosenberg, Carroll, and Charles Rosenberg. "The Female Animal: Medical and Biological Views of Woman and Her Role in Nineteenth-Century America." *The Journal of American History*, 1973, 332-56. Accessed March 17, 2015. JSTOR.

Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1982.

Theriot, Nancy M. *Mothers and Daughters in Nineteenth-century America: The Biosocial Construction of Femininity*. Lexington, KY: University Press of Kentucky, 1996.

Tuchman, Arleen. *Science Has No Sex: The Life of Marie Zakrzewska, M.D.* Chapel Hill: University of North Carolina Press, 2006.

Verbrugge, Martha H. "Women and Medicine in Nineteenth-Century America." *Signs: Journal of Women in Culture and Society* 1, no. 4 (1976): 957-72. Accessed April 1, 2015. JSTOR.

Vogel, Morris J. *The Therapeutic Revolution: Essays in the Social History of American Medicine*. Philadelphia: University of Pennsylvania Press, 1979.

Waller, John. *Health and Wellness in 19th-Century America*. Santa Barbara: ABC-CLIO, 2014. <http://WELL.ebib.com/patron/FullRecord.aspx?p=1786698> (accessed April 07, 2015)

Wells, Susan. *Out of the Dead House: Nineteenth-Century Women Physicians and the Writing of Medicine*. Madison: University of Wisconsin Press, 2001.

Wertz, Richard W., and Dorothy C. Wertz. *Lying-in: A History of Childbirth in America*. Expanded ed. New Haven: Yale University Press, 1989.

Wilsford, David. *Doctors and the State: The Politics of Health Care in France and the United States*. Durham: Duke University Press, 1991.

Woodward, John. *Health Care and Popular Medicine in Nineteenth Century England: Essays in the Social History of Medicine*. New York: Holmes & Meier Publishers, 1977.